The newsletter of Ireland's focal point to the EMCDDA

drugnet IRELAND

Issue 60 | Winter 2017

In this issue

Review on case management in addiction services
See pages **15–17**

Club Health 2017 conference in Dublin
See page 24

06 Alcohol policy in Ireland and Scotland

10 Sixth ESPAD survey

12 Psychiatric admissions

13 Substance use and parenting

18 Naloxone Demonstration Project

Drugnet Ireland is produced in collaboration with the HRB National Drugs Library. To have *Drugnet Ireland* delivered to your desktop, sign up at **www.drugsandalcohol.ie**

Results from fourth general population survey on drug use in Ireland

L–R: Author of the *Evaluation of the HSE Naloxone Demonstration Project* Dr Ann Eustace, Minister of State for Communities and the National Drugs Strategy, Catherine Byrne TD and HSE National Director Primary Care John Hennessy attending the launch of the report (see p. 18)

The first survey on drug use in the general population was carried out in Ireland in 2002/3. The results were jointly published by the National Advisory Committee on Drugs (NACD), now the National Advisory Committee on Drugs and Alcohol (NACDA), and the Drug and Alcohol Information and Research Unit. The survey was repeated in 2006/7 and in 2010/11.[1] In 2014, the NACDA commissioned IPSOS MRBI to conduct the Ireland and Northern Ireland drug prevalence survey 2014/15.[2]

HRB Health Research Board

Research. Evidence. Action.

Contents

The policy, research and other documents covered in this issue of *Drugnet Ireland* have all been retrieved by the HRB National Drugs Library and may be accessed on its website **www.drugsandalcohol.ie**

In brief

Developing and implementing effective responses to the drugs situation requires an efficient and scientific system of monitoring so policy-makers can act using sound and dependable information. Ireland is well served in terms of the supply of population data that allows us to develop detailed and reliable pictures describing the extent and nature of drug trends over time. Various health surveillance systems provide the data on which analysis of the consequences of problem drug use, and the responses in place to alleviate or prevent them, can be built.

A number of articles in this issue illustrate the extent to which policy in Ireland is supported by up-to-date, robust and comparable data on the drug situation. We present the main findings from the recently published 2014/15 survey on drug use in the general population, the fourth iteration of this survey which was first carried out in 2002/3. The main focus on the findings of general population studies is on the younger cohorts, and the information from the general population survey is complemented by data from several other sources. Another article presents the findings from the Irish section of the European School Survey Project on Alcohol and Other Drugs (ESPAD) that has conducted surveys of school-going children every four years since 1995. Findings from general health surveys and longitudinal studies provide further insight into patterns of behaviour among the 15–34-years age groups.

Policy-makers and service planners need this monitoring framework to measure both the overall prevalence of drug use and of drug dependency and to make predictions around the demand for services based on the likely consequences of these prevalence levels. While such data is essential for the creation of an accurate picture of the overall drugs situation, effective targeting of resources, particularly in the demand reduction area, requires both a broader selection of data sources and a narrower focus in terms of subject. Recent analysis of data from the Dunedin Longitudinal Study in New Zealand demonstrates that the risk factors leading to greater use of health, social and security services in adulthood can be identified at a very young age. Details on personal circumstances combined with demographic information are clearly associated with a range of health and behavioural problems, including substance use, later in life. Creative use of existing datasets will enable researchers to define these patterns more clearly and provide information which can be used to help services to become more targeted and effective.

General population survey continued

The 2014/15 survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The questionnaire, based on the European Model Questionnaire, was administered in face-to-face interviews with respondents aged 15+ years. A sample comprising all households throughout the island of Ireland was randomly selected to participate and fieldwork began in September 2014 and was completed in May 2015. Of the household members contacted, 7005 agreed to take part. The sample was weighted by gender, age and region to ensure that it was representative of the general population. The main measures were lifetime (ever used) use, use in the last year (recent use) and use in the last month (current use).

Use of any illegal drug

The proportion of respondents aged 15–64 years who reported using any illicit drug in their lifetime has increased from 19% in 2002/3 to almost 31% in 2014/15 (Figure 1). There has also been an increase when compared to the 2010/11 study (27%).

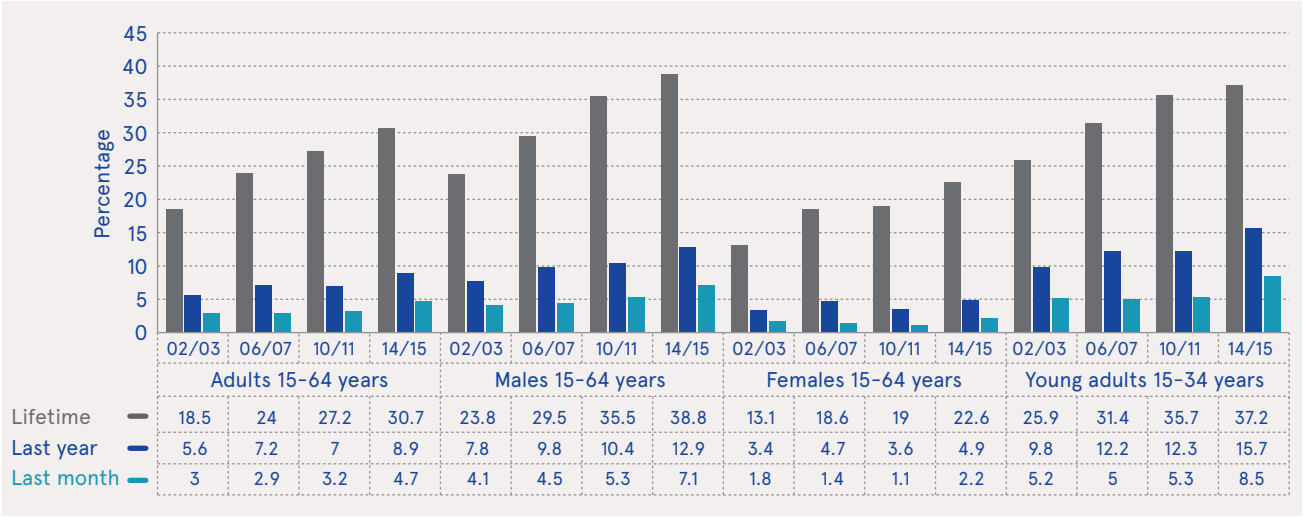
Similarly, last year and last month prevalence of any illegal drug use has increased since the previous survey; from 7% to 9% and 3% to 5%, respectively. Any illegal drug refers to the use of cannabis, ecstasy, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances (NPS), solvents, crack and heroin.

Illicit drug use was more prevalent in males, and was also greater among young adults, with almost 9% of persons aged 15–34 years having reported illegal drug use within the previous month (compared to 5% in 2010/11). Results from the 2014/15 survey indicated that the most commonly used illicit substances in Ireland, based on last month prevalence, were cannabis (4%), ecstasy (1%) and cocaine (0.5%).

Cannabis use

Findings revealed that 28% of the population (15–64 years) had used cannabis at some point in their lives; 8% reported use in the year prior to the survey; and 4% indicated use in the preceding month. All of these rates are higher than those recorded in previous surveys within Ireland (Figure 2).

Figure 1: Lifetime, last year and last month prevalence of any* illicit drug use in Ireland, 2002/3, 2006/7, 2010/11 and 2014/15

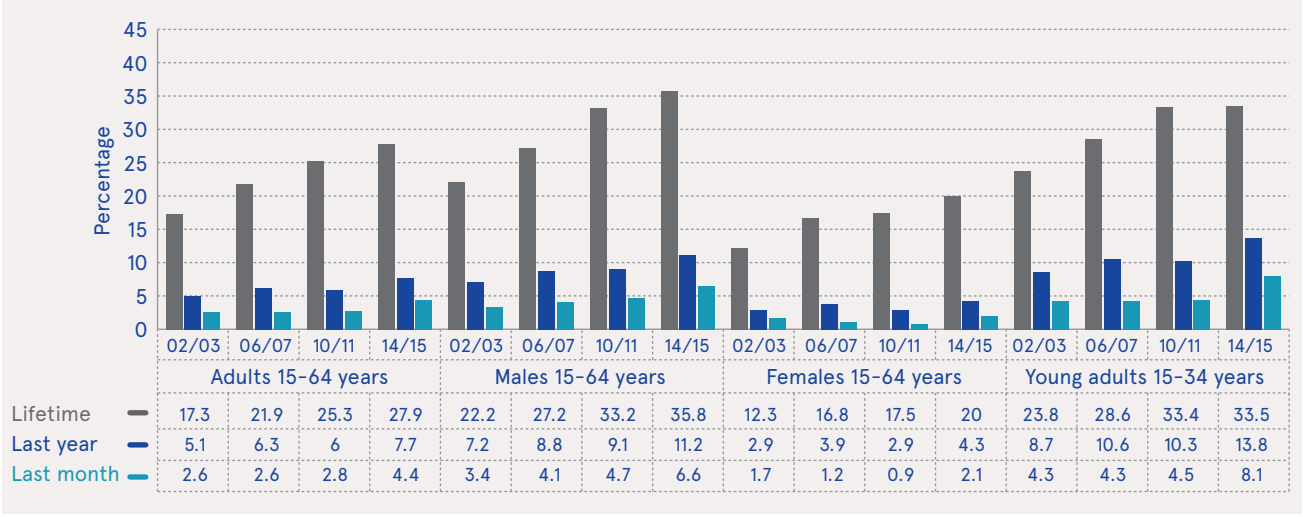


	Adults 15-64 years				Males 15-64 years				Females 15-64 years				Young adults 15-34 years			
	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15
Lifetime	18.5	24	27.2	30.7	23.8	29.5	35.5	38.8	13.1	18.6	19	22.6	25.9	31.4	35.7	37.2
Last year	5.6	7.2	7	8.9	7.8	9.8	10.4	12.9	3.4	4.7	3.6	4.9	9.8	12.2	12.3	15.7
Last month	3	2.9	3.2	4.7	4.1	4.5	5.3	7.1	1.8	1.4	1.1	2.2	5.2	5	5.3	8.5

Source: NACDA, 2016

**Any illicit drug refers to the use of cannabis, ecstasy, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, solvents, crack and heroin*

Figure 2: Lifetime, last year and last month prevalence of cannabis use in Ireland, 2002/3, 2006/7, 2010/11 and 2014/15



	Adults 15-64 years				Males 15-64 years				Females 15-64 years				Young adults 15-34 years			
	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15
Lifetime	17.3	21.9	25.3	27.9	22.2	27.2	33.2	35.8	12.3	16.8	17.5	20	23.8	28.6	33.4	33.5
Last year	5.1	6.3	6	7.7	7.2	8.8	9.1	11.2	2.9	3.9	2.9	4.3	8.7	10.6	10.3	13.8
Last month	2.6	2.6	2.8	4.4	3.4	4.1	4.7	6.6	1.7	1.2	0.9	2.1	4.3	4.3	4.5	8.1

Source: NACDA, 2016

Similar to earlier studies, rates of cannabis use were greater among men than women: (36% vs 20%) lifetime use; (11% vs 4%) last year use; and (7% vs 2%) last month use. Since 2002/3, lifetime rates of cannabis use among males have increased by 61% and last month use by 94%. Lifetime use of cannabis among females has also increased (20% in 2014/15 vs 12% in 2002/3). However, last month prevalence in women has remained relatively stable over time.

The prevalence of cannabis use was noticeably higher among young adults (15–34 years). Lifetime rates were similar to those reported in 2010/11 (34%). Last year and last month prevalence rates were higher than those recorded in the previous survey (14% vs 10% and 8% vs 5%), and the proportion of young adults who classified themselves as current users of cannabis has almost doubled since 2002/3. Approximately 13% of males and 6% of females aged 15–34 years indicated that they had used cannabis in the month prior to the survey. Lifetime, last year and last month rates of cannabis use among adults aged 35-64 years were 24%, 3% and 2%, respectively.

Cocaine use

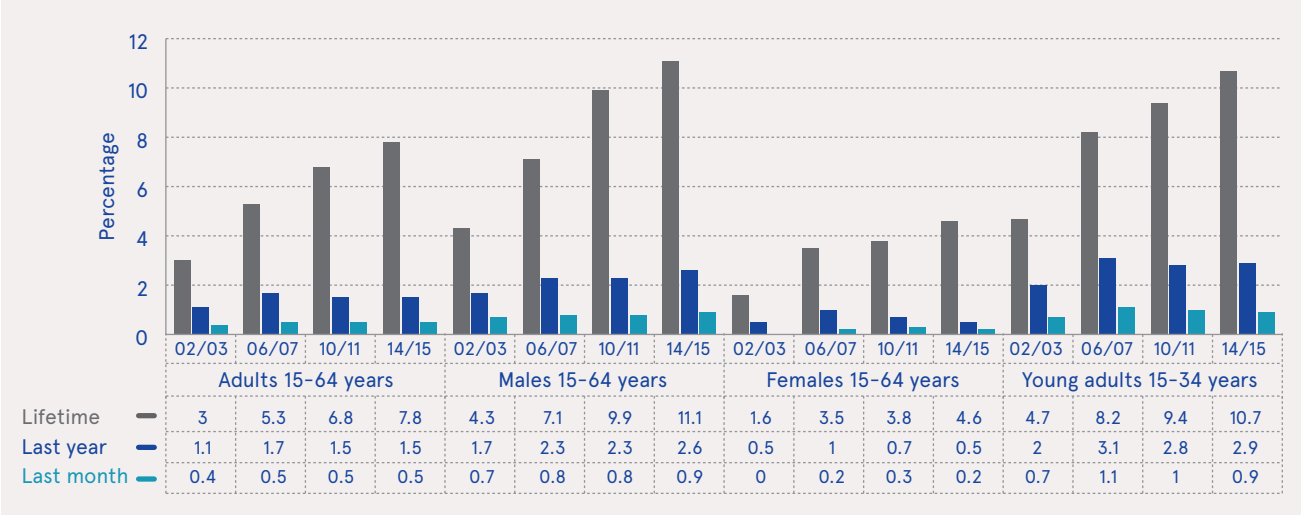
Lifetime cocaine use has increased when compared to 2010/11 (Figure 3). The percentage of respondents aged 15–64 years who reported using cocaine (including crack) at some point in their lives increased from 7% to 8%. The proportion of young adults (15–34 years) who reported using cocaine in their lifetimes has also increased from 9% to 11%.

As was observed in previous studies, more men reported using cocaine in their lifetimes compared to women (11% vs 5%). However, although the lifetime rate of cocaine use among persons aged 15–64 years and young adults aged 15–34 years has more than doubled since 2002/3, the percentage of respondents reporting current use of cocaine has remained relatively unchanged across surveys.

Ecstasy use

In Figure 4, significant increases in lifetime and last year prevalence of ecstasy use were observed in persons aged 15–64 years (7% to 9% and 0.5% to 2%, respectively).

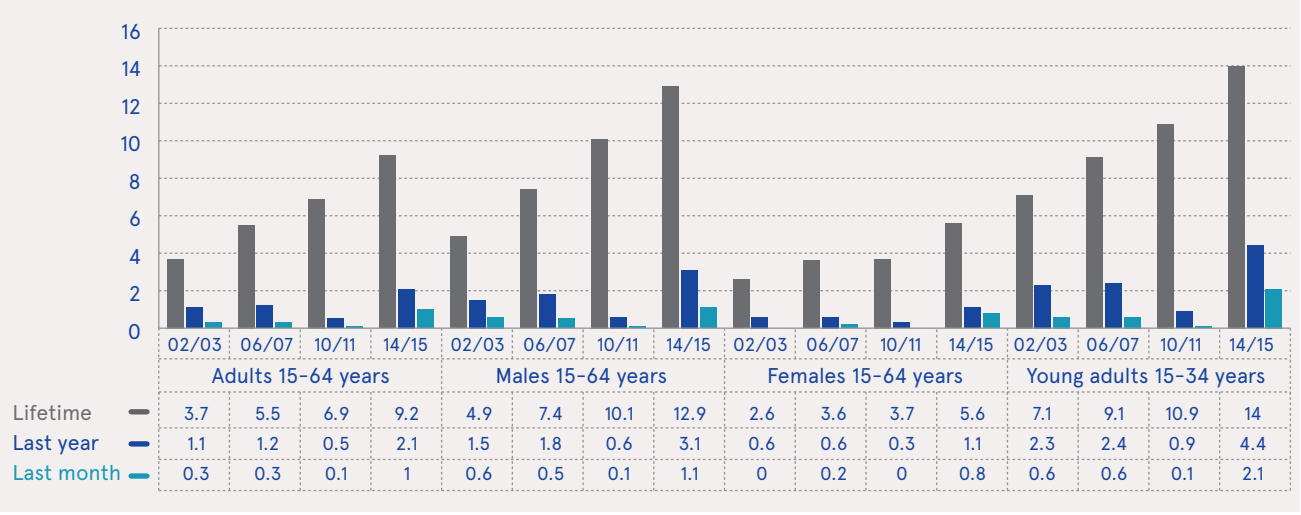
Figure 3: Lifetime, last year and last month prevalence of cocaine use (including crack) in Ireland, 2002/3, 2006/7, 2010/11 and 2014/15



	Adults 15-64 years				Males 15-64 years				Females 15-64 years				Young adults 15-34 years			
	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15
Lifetime	3	5.3	6.8	7.8	4.3	7.1	9.9	11.1	1.6	3.5	3.8	4.6	4.7	8.2	9.4	10.7
Last year	1.1	1.7	1.5	1.5	1.7	2.3	2.3	2.6	0.5	1	0.7	0.5	2	3.1	2.8	2.9
Last month	0.4	0.5	0.5	0.5	0.7	0.8	0.8	0.9	0	0.2	0.3	0.2	0.7	1.1	1	0.9

Source: NACDA, 2016

Figure 4: Lifetime, last year and last month prevalence of ecstasy use in Ireland, 2002/3, 2006/7, 2010/11 and 2014/15



	Adults 15-64 years				Males 15-64 years				Females 15-64 years				Young adults 15-34 years			
	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15	02/03	06/07	10/11	14/15
Lifetime	3.7	5.5	6.9	9.2	4.9	7.4	10.1	12.9	2.6	3.6	3.7	5.6	7.1	9.1	10.9	14
Last year	1.1	1.2	0.5	2.1	1.5	1.8	0.6	3.1	0.6	0.6	0.3	1.1	2.3	2.4	0.9	4.4
Last month	0.3	0.3	0.1	1	0.6	0.5	0.1	1.1	0	0.2	0	0.8	0.6	0.6	0.1	2.1

Source: NACDA, 2016

Fourteen per cent of young adults (15–34 years) claimed to have tried ecstasy at least once in their lifetime, with over 4% having used it within the last year (vs 0.9% in 2010/11) and 2% indicating current use (vs 0.1% in 2010/11). Almost 10% of males and 4% of females aged 15–24 years reported using ecstasy within the previous year, while current use was 4% (males) and approximately 3% (females) for the same age category.

Previous findings from the 2010/11 survey had suggested a decline in the use of ecstasy among younger Irish adults when compared to earlier studies. This was possibly due to the increased use of NPS sold in head shops and online.[3]

New psychoactive substances (NPS)

In 2014/15, the lifetime prevalence of NPS use among respondents aged 15–64 years was approximately 4%, while last month prevalence was less than 1%. In male adults aged 35-44 years, and those aged 45–54 years, lifetime prevalence rates were 3% for both. For females, the corresponding rates were 1.2% and 0.9%, respectively. Last month prevalence of NPS use for both age categories was less than 1% in both genders.

Last year prevalence of NPS use was included as a drug category for the first time in the 2010/11 NACDA drug prevalence survey. In contrast to trends observed with other illicit substances, data from the 2014/15 study demonstrate a reduction in the use of NPS in the Irish population in both genders (Figure 5). The percentage of male and female young adults aged 15–24 years who indicated current use of NPS was also less than 1%.

The low prevalence of current NPS use among younger Irish adults, and decreasing trends in NPS use among respondents aged 15–64 years of both genders, may be as a result of the Criminal Justice (Psychoactive Substances) Act 2010, which came into effect in August 2010. The Act made it an offence, punishable by up to five years' imprisonment, to sell or supply for human consumption substances which are not specifically proscribed under the Misuse of Drugs Acts, but which have psychoactive effects.[4]

Nevertheless, despite a decline in the use of NPS, the results from the 2014/15 survey indicate an increase in the use of illicit substances within Ireland. This is largely due to an increase in the use of cannabis and ecstasy among younger adults, and in particular young males.

Although opioids were included as a drug category in this study, the prevalence of heroin use was low, as the Ireland and Northern Ireland drug prevalence survey 2014/15 is a general population survey. Thus, persons who do not normally reside in private households have not been included. A national three-source capture-recapture (CRC) study to provide statistically valid estimates of the prevalence of opiate drug use in the national population was commissioned by the NACDA and undertaken in 2001[5] and 2006.[6] The three data sources used were the Central Treatment List (of clients on methadone), the Hospital In-Patient Enquiry (HIPE) scheme, and Garda PULSE data. A third study using the CRC method was commissioned in 2014, and a final report is due to be published shortly.

Seán Millar

1 National Advisory Committee on Drugs (NACD) and Public Health Information and Research Branch (PHIRB) (2011) *Drug use in Ireland and Northern Ireland: first results from the 2010/11 Drug Prevalence Survey.* Bulletin 1. Dublin: NACD and PHIRB. http://www.drugsandalcohol.ie/16353/

2 National Advisory Committee on Drugs (NACDA) and Department of Health (DoH) UK (2016) *Prevalence of Drug Use and Gambling in Ireland and Drug Use in Northern Ireland.* Bulletin 1. Dublin: NACD and DoH. http://www.drugsandalcohol.ie/26364/

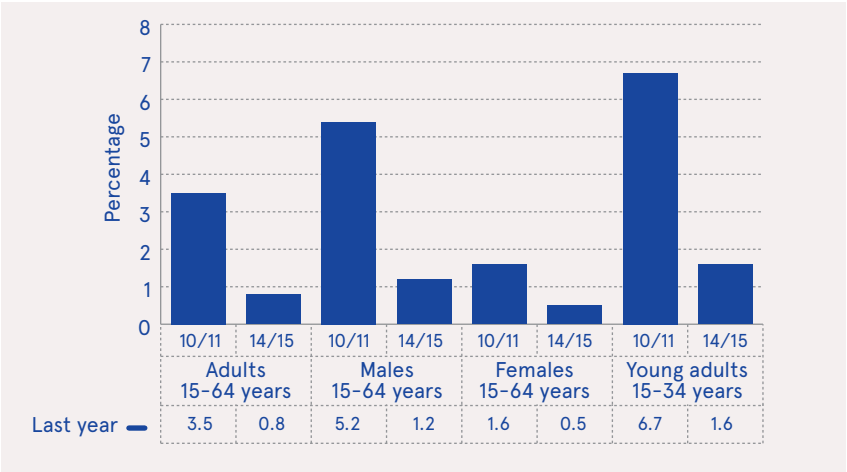
3 Long J (2012) Results from the third general population survey in Ireland. *Drugnet Ireland*, 40: 6–8. http://www.drugsandalcohol.ie/16866/

4 Criminal Justice (Psychoactive Substances) Act 2010. Available online at http://www.irishstatutebook.ie/eli/2010/act/22/enacted/en/html

5 Kelly A, Carvalho M and Teljeur C (2003) *Prevalence of opiate use in Ireland 2000–2001: a 3-source capture recapture study: a report to the National Advisory Committee on Drugs Sub-Committee on Prevalence.* Dublin: Stationery Office. http://www.drugsandalcohol.ie/5942/

6 Kelly A, Teljeur C and Carvalho M (2009) *Prevalence of opiate use in Ireland 2006: a 3-source capture recapture study: a report to the National Advisory Committee on Drugs.* Dublin: Stationery Office. http://www.drugsandalcohol.ie/12695/

Figure 5: Last year prevalence of NPS use among adults in Ireland, 2010/11 and 2014/15



Source: NACDA, 2016

POLICY AND LEGISLATION

Minimum unit pricing backed by courts in Scotland

On 21 October 2016, the Court of Session in Edinburgh ruled against a challenge to the introduction of minimum unit pricing (MUP) in Scotland, brought by the Scotch Whisky Association and others.[1] Essentially, the case concerned a measure (MUP) that the Scottish government argued would help to reduce alcohol-related harm, while the producers and sellers of alcohol argued that it inhibited their right by law to trade freely across the EU.

The Alcohol (Minimum Pricing) (Scotland) Act was passed in June 2012: 86 members of the Scottish Parliament voted in its favour, one voted against and 32 abstained. In line with the Act, the minimum price was to be calculated according to a formula: MPU × S × V × 100 (minimum price per unit × strength of the alcohol × volume of the alcohol in litres). In 2013, Scotland set the MUP at 50p (approx. 55c) – a 70cl bottle of spirits with an ABV (alcohol by volume) of 40% would retail at a minimum of £14 (€15.50). This formula and the case for introducing MUP more broadly were informed by research conducted by experts from the Sheffield Alcohol Research Group (SARG) at the University of Sheffield. These experts have also applied their modelling to the Irish context.[2]

Central to the judgement in October was the question whether or not MUP was a proportionate policy under EU law – in other words, are there more public health benefits to be achieved by introducing MUP than could be achieved by other existing policy options, in particular increased taxation on alcohol? Those opposing MUP argued that changes in taxation would be a more suitable course of action. However, in delivering its ruling, the court stated that:

> The fundamental problem with an increase in tax is simply that it does not produce a minimum price [para. 196] .... The advantage of the proposed minimum pricing system, so far as protecting health and life is concerned, is that it is linked to the strength of the alcohol. Current EU tax arrangements relate to different types of product (wine, spirits, beer and cider etc) each of which has a range of ABVs .... they do not permit taxation of wines at variable rates according to the strength of alcoholic content. Minimum pricing permits lower pricing to be charged for lower strength alcohol [para. 198].[1]

While the ruling paved the way for the Scottish government to implement the Act, in November 2016 the Scotch Whisky Association launched an appeal on the decision to the UK Supreme Court in London.

Lucy Dillon

1 The full Court of Session judgement is available online at https://www.scotcourts.gov.uk/search-judgments/judgment?id=9a1821a7-8980-69d2-b500-ff0000d74aa7

2 For a discussion on the Sheffield research applied to the Irish context, see *Drugnet Ireland*, 56, 'Minimum unit pricing for alcohol: what will it really mean?'. http://www.drugsandalcohol.ie/25136/

Alcohol policy in Ireland and Scotland

On 2 March 2016, Scottish Health Action on Alcohol Problems (SHAAP), Alcohol Focus Scotland and Eurocare held a joint event in Edinburgh to discuss alcohol policy in Scotland and Ireland. They subsequently published the proceedings of the event in *Alcohol policy in Scotland and Ireland: European trailblazers or Celtic fringes?*[1] The event came about as governments in both countries promoted policies that focused on increasing the price of alcohol, reducing its availability, and restricting its marketing. Similarly, both governments were seen to face sustained opposition from global alcohol producers in implementing these policies.

The published proceedings contain the five papers presented on the day and notes from the final discussion session.

'Europe and alcohol: challenges and opportunities', Marian Skar, Eurocare: The European Alcohol Policy Alliance

Eurocare's main goal is to raise awareness among EU decision-makers about the social, health and economic harms caused by alcohol. They aim to ensure that these harms are taken into consideration in all relevant EU policy discussions. Their second main goal is to promote evidence-based policies aimed at 'effectively preventing and reducing the burden of alcohol'. Based on the World Health Organization's strategy, Eurocare's motto is 'less is better'. Skar highlighted that there is no current EU alcohol strategy. Despite the European Parliament passing a resolution on the alcohol strategy, she thought it 'highly doubtful' that one would result. However, she described European-level non-governmental organisation (NGO) collaboration on alcohol as 'good' and recommended that they focus on cross-border issues. She also spoke about alcohol pricing, marketing and advertising regulations, consumer information, drink driving, and data gathering and monitoring.

'Monitoring and evaluating Scotland's alcohol strategy (MESAS) 2016: evaluating Scottish alcohol policy', Clare Beeston, NHS Health Scotland

Scotland has a multi-component alcohol strategy that makes its evaluation difficult. Beeston described the theory of change approach underpinning the evaluation and its strengths and weaknesses. She also identified a number of conclusions that could be drawn from the evaluation. It found a decline in population consumption of alcohol between 2009 and 2012, as well as a reduction in alcohol-related death rates and hospitalisations since their peak in the mid-2000s. Overall, MESAS found that the implementation of the alcohol strategy has led to some

Alcohol policy in Ireland and Scotland continued

positive change in intermediate outcomes. However, Beeston also expressed concern about the finding that alcohol consumption is flattening and that there has been no further decline in mortality or morbidity in the last two years.

'Whisky galore? Policy challenges and priorities in Scotland', Alison Douglas, chief executive, Alcohol Focus Scotland

Douglas described the pattern of alcohol consumption in Scotland, highlighting the widespread harms experienced in particular in deprived communities. She argued that in terms of cost-effectiveness of interventions to reduce consumption and harm, the three 'best buys' were to take action on alcohol pricing, availability, and marketing. They were to be seen as mutually reinforcing and should therefore be implemented 'collectively'.

'Finding the right measure? Policy challenges and priorities in Ireland', Suzanne Costello, chief executive, Alcohol Action Ireland

Costello described Irish alcohol consumption patterns, emphasising that 'binge drinking is a real problem in Ireland'. Alcohol-related harms were highlighted, including alcohol-related deaths, and their role in deaths by suicide in Ireland. Addressing Ireland's drinking 'culture' was described as presenting a particular challenge. As with previous speakers, she identified alcohol pricing, availability, consumer information, and advertising and marketing as requiring action if consumption and harms were to be addressed. These reflected some of the key elements of the Public Health (Alcohol) Bill 2015 that was described, including the use of product labels to contain a link to a public health website providing information on alcohol and its related harms. She concluded that at the time of presenting, the Irish political landscape was 'much more favourable to health issues'.

Lucy Dillon

1 Scottish Health Action on Alcohol Problems (2016) *Alcohol policy in Scotland and Ireland: European trailblazers or Celtic fringes?* Edinburgh: Scottish Health Action on Alcohol Problems. http://www.drugsandalcohol.ie/26101/

Joint Strategy on the Management of Offenders

On 22 September 2016, the Tánaiste and Minister for Justice and Equality, Frances Fitzgerald TD launched the first Joint Strategy for the Management of Offenders.[1] The strategy, which builds on existing collaborative work between the Irish Prison Service (IPS), the Probation Service (PS) and An Garda Síochána (AGS), highlights two areas, namely the management of offenders along with a strong focus on the rights of victims. What follows is an outline of the main objectives and accompanying actions to go forward between 2016 and 2018.

More integrated management

It was announced that the Joint Agency Response to Crime (JARC) would be extended into three more areas: Dundalk, Waterford City and Limerick City. JARC will be evaluated to inform future developments and an online platform E-JARC will be developed to support communication between agencies. Engagement by the IPS, the PS and AGS with the Courts Service will aim to produce shared information technology.

Multi-agency response to management of sex offenders

The Department of Justice and Equality intends to have the Sex Offender Risk Assessment and Management (SORAM) model ratified legally. SORAM will then be officially launched via a national conference. The research findings of the initial pilot will inform how SORAM will be implemented nationally.

In collaboration with the housing sector, the problem of finding accommodation for high-risk sex offenders will also be addressed. Future explorations will examine the viability of expanding the SORAM model to include other offences.

Sharing good interagency information

The intention is to explore other opportunities for sharing information among agencies:

- AGS will provide 'précis of evidence' nationwide (p. 4) to assist preparation of pre-sanction reports.
- Protocols will be agreed by the IPS and PS regarding confidentiality on the sharing of pre-sanction assessment reports.
- Agreements will be made by AGS with the PS and IPS to allow Gardaí access to information on offenders who are on probation and in prison.
- Agencies will ensure that information is shared regarding prisoners who are unlawfully at large.

Creating more efficient system of implementing court orders

The PS and AGS will be responsible for outlining a course of action to deal with cases not meeting the terms of court orders and warrants issued as a result of non-cooperation. A system will be created to keep a record of warrants issued and how they can be retrieved and implemented.

Addressing consequences of domestic violence in communities

In order to deal with domestic violence, the aim is to develop stronger ties, common language and understanding between AGS, the IPS and PS. This will include the use of warning systems, joint training, and exchanging information on how to assess and manage offenders.

Joint Strategy on the Management of Offenders continued

Agencies will continue to work with Tusla to detect and manage child protection cases and with COSC (the National Office for the Prevention of Domestic, Sexual and Gender-based Violence) to help support intervention programmes for offenders of domestic violence.

Benefits of joint training at operational and management levels

It is proposed that training exchanges will be developed between AGS, the PS and IPS. Joint training will be undertaken by these agencies in areas such as domestic violence, management of sex offenders, and awareness of radicalisation to violent extremism.

Reintegration and community management of vulnerable offenders

The IPS and PS will continue to develop the reintegration of vulnerable prisoners and the Irish Prison Service / Central Mental Hospital Court diversion programmes. These agencies will also work with the Health Service Executive to enhance existing practice protocols.

Advancing North–South cooperation

The intention is to continue the sharing of information between agencies in Northern Ireland and the Republic. In addition, agencies will attend the annual Public Protection Advisory Group seminar to share information with the view to improving current practice.

Protecting victims of crime and upholding their rights

The PS, IPS, AGS and Department of Justice and Equality will attend a specially convened meeting that aims to develop a unified approach to working with victims of crime. A close working relationship between agencies will ensure that obligations under the EU Victims Directive are met. The Victim Service teams of these agencies will collaborate and develop suitable codes of behaviour for responding to the rights and needs of victims.

Minister Fitzgerald welcomed 'the commitment in the strategy of all three agencies to work together to address the serious consequences of domestic violence in our community; this heinous crime in our community can only be reduced with the dedicated focus outlined in the strategy'.[2]

Ciara H Guiney

1 Department of Justice and Equality (2016) *Joint strategy on the management of offenders 2016–2018.* Dublin: Department of Justice and Equality. Available online at http://www.drugsandalcohol.ie/26661/

2 Department of Justice and Equality (2016) *Tánaiste launches Joint Strategy on the Management of Offenders and announces the extension of Joint Agency (JARC) initiative to Dundalk, Limerick city and Waterford city.* Available online at http://www.justice.ie/en/JELR/Pages/Extension-of-Joint-Agency-J-ARC-initiative

Responses to UNGASS 2016

The United Nations General Assembly Special Session (UNGASS) on the world drug problem was held in April 2016. It attracted formal responses from a variety of civil society bodies working in the area of drug policy. This article looks at responses from two of these bodies – the International Drug Policy Consortium (IDPC) and the Global Commission on Drug Policy (GCDP). UNGASS-related publications by these bodies were included in earlier issues of *Drugnet Ireland*, as part of the 'Towards UNGASS 2016' column.[1]

International Drug Policy Consortium

The IDPC is a global network of 163 NGOs. It focuses on issues related to drug production, trafficking and use, and promoting objective and open debate on the effectiveness, direction and content of drug policies at national and international levels. The network supports evidence-based policies that are effective at reducing drug-related harm.[2]

In September 2016, the IDPC published its version of the proceedings of the UNGASS.[3] The document provides a summary of each of the sessions held – the plenary and the five roundtable discussions on: (1) drugs and health; (2) drugs and crime; (3) cross-cutting issues: drugs and human rights, youth, women, children and communities; (4) new challenges, threats and realities; and (5) drugs and development. The summaries include a focus on the input of civil society representatives, and highlight where there was a lack of consensus between country representatives.

In addition to the summaries, the report provides an overall critique of the UNGASS process. From the outset, the IDPC is critical of the central role of the pre-negotiated UNGASS outcome statement.[4] It describes it as having being negotiated through a process characterised by a 'lack of transparency and accountability'. By virtue of the document having been essentially finalised prior to UNGASS, 'a number of barriers were in place to hinder civil society participation. This all served to ensure that the UNGASS was not the drug policy revolution that some stakeholders seemed to be expecting'. The report also describes barriers to civil society participating at the UNGASS event itself. For example: the restrictions and censorship placed on their distribution of literature and reports; and access to sessions being denied to a significant number of civil society attendees on the day, despite having previously confirmed attendance. Despite these barriers, the IDPC argues that 'the voice of civil society – including affected populations such as people who use drugs – was strongly heard at the UNGASS, both in the preparations and the meeting itself'.

While the report tends to be critical of the UNGASS outcome statement, the IDPC also concedes that it 'undoubtedly takes a step forward from previous commitments [at UN level] – not least in terms of access to medicines, human rights, overdose prevention and proportionate sentencing'.

Responses to UNGASS 2016

continued

However, based on other elements of the UNGASS (e.g. the roundtable and plenary sessions, and inputs from civil society and country statements), it describes the so-called 'Vienna Consensus' (manifest in the outcome document) as 'irreversibly shattered' in light of the 'divergent stances' of member states – it described these as 'impossible to ignore on key issues such as the death penalty, decriminalisation, regulated markets and development'.

In conclusion, the report identified that:

> The challenge now for the drug policy reform sector is to maintain the momentum and attention which the UNGASS managed to achieve – within the UN, the media and broader civil society. This requires a concerted effort to keep the fire burning, rather than leaving it to burn out and to build on the steps forward and lessons learned to ensure further significant shifts in 2019 or 2020 [at the next UN review of the drug problem].

Global Commission on Drug Policy

The GCDP describes itself as made up of 25 political leaders and leading thinkers from across the political spectrum. It sets out to 'bring to the international level an informed, science-based discussion about humane and effective ways to reduce the harm caused by drugs to people and societies'.[5]

On the final day of the UNGASS, the GCDP issued a public statement on the event.[6] It described itself as 'profoundly disappointed' with the adopted UNGASS outcome statement. It argued that:

> The document does not acknowledge the comprehensive failure of the current drug control regime to reduce drug supply and demand. Nor does the outcome document account for the damaging effects of outdated policies on violence and corruption as well as on population health, human rights and wellbeing.

The UNGASS outcome statement was perceived to have sustained 'an unacceptable and outdated legal status quo' by reaffirming the three international conventions as 'the cornerstone of global drug policy'.

The GCDP criticised UNGASS for not seriously addressing what it sees as 'the critical flaws of international drug policy', including the criminalisation of drug users; the use of capital punishment for drug-related offences; and, the World Health Organization's scheduling system of drugs. It also identified UNGASS as having failed both to advocate for harm reduction and treatment strategies that have been found to be effective and to offer proposals to regulate drugs and 'put governments – rather than criminals – in control'.

The GCDP identified the outcome document as failing to recognise the considerable support for change demonstrated by many governments and civil society groups, and the 'many positive drug policy reforms already underway around the world'. It described as vital that the tensions between the restrictions imposed by the international narcotics conventions and ongoing initiatives on the ground are resolved. In conclusion, it encourages and supports governments and civil societies in their efforts 'to fundamentally realign drug policy so that health, citizen safety and human rights are paramount'.

Lucy Dillon

1 International Drug Policy Consortium: http://www.drugsandalcohol.ie/25130/; Global Commission on Drug Policy: http://www.drugsandalcohol.ie/23301/ and http://www.drugsandalcohol.ie/23684/

2 For more information on the International Drug Policy Consortium, visit http://idpc.net

3 *The United Nations General Assembly Special Session (UNGASS) on the world drug problem: report of proceedings* (2016). IDPC: London. http://www.drugsandalcohol.ie/26049/

4 As outlined in issue 58 of *Drugnet Ireland* (http://www.drugsandalcohol.ie/25954/), two key policy statements to emerge from the UNGASS process were: the EU common position; and the UNGASS outcome statement. The UNGASS outcome statement was agreed by member states at the 59th meeting of the UN Commission on Narcotic Drugs (CND) in Vienna in March 2016, and was adopted at the start of the UNGASS.

5 For more information on the Global Commission on Drug Policy, visit http://www.globalcommissionondrugs.org

6 *Public statement by the Global Commission on Drug Policy on UNGASS 2016* (2016). Available online at http://www.globalcommissionondrugs.org/wp-content/uploads/2016/04/FINALpublicstatementforGCDP.pdf

PREVALENCE AND CURRENT SITUATION

Sixth ESPAD survey report published

The European School Survey Project on Alcohol and Other Drugs (ESPAD) has conducted surveys of school-going children every four years since 1995 using a standardised method and a common questionnaire. The sixth survey was undertaken in 35 European countries during 2014/15 and collected information on alcohol, tobacco and other substance use among 15–16-year-old students.

An important goal of the ESPAD survey is to monitor trends in alcohol consumption, tobacco and other drug use among 15–16-year-olds and to compare trends between countries and groups of countries. It also provides an opportunity to observe changes in trends in Ireland over the six waves of the past 20 years. The rationale for the ESPAD surveys is that school students are easily accessible and at an age when the onset of substance use is likely to occur.

This article concentrates on findings from the survey conducted in Ireland in 2014/15, in which 2036 questionnaires were completed by young people from 50 randomly selected post-primary schools.[1] Of these participants, 1493 were born in 1999 and will be included in the international ESPAD dataset.

Alcohol use

Respondents were asked on how many occasions in their lifetime had they used alcohol. Just over one-quarter (26.4%) answered that they had never consumed an alcoholic beverage in their lifetime. Overall, 73.6% of students had drunk alcohol in their lifetime, with almost 20% having tried alcohol once or twice. Sixteen per cent had drunk alcohol on more than 20 occasions. Significant gender differences in lifetime use of alcohol were noted, with more female (75.3%) than male (72%) respondents having ever consumed alcohol. Male students, however, were more likely to have tried alcohol 40 times or more (10.7%) than females (7.5%).

Thirty-six per cent of students had drunk alcohol in the past 30 days and were considered to be current drinkers. Twenty-one per cent reported drinking alcohol once or twice in the past 30 days, while only a small proportion of respondents had used alcohol 10 times or more (3.4%). Similar to lifetime use, more female (37.1%) than male (34.9%) students indicated current alcohol use. Nevertheless, overall, current alcohol use among students in Ireland has declined (Table 1), with a 28% reduction since 2011 and a 48% reduction over the past 20 years.

Respondents who drank alcohol were asked to rate their level of intoxication. Fourteen per cent of students reported being drunk in the past 30 days and 40 students reported being drunk more than once or twice during the past month (3.0%). A similar number of male (14.7%) and female (13.2%) students reported being drunk in the past month and there was no significant difference in mean score on the drunkenness scale between male (Mean=3.20, SD=1.848) and female (Mean=3.12, SD=1.742) students.

Table 1: Alcohol use in the past 30 days among 15–16-year-olds in Ireland since 2003

Alcohol use in the past 30 days	2003 (%)	2007 (%)	2011 (%)	2015 (%)
Males	71	57	48	35
Females	74	56	52	37
All subjects	73	56	50	36

Source: ESPAD Ireland, 2016

Beer (28.6%), spirits (24.5%) and cider (21.3%) were the most common types of alcohol consumed in the month prior to the survey. The least popular drinks were wine (11.9%) and alcopops (11.4%). Respondents were asked how difficult they thought it would be to obtain specific alcoholic beverages, with response categories ranging from 'impossible' to 'very easy'. A majority of students believed that it would be fairly easy to obtain all beverage types examined; 37.8% gave this answer for beer and 34.7% for cider. A high percentage of students also said it would be very easy to get beer (31.9%) or cider (30.2%), while only 5.2% said it would be impossible to get beer, with 7% reporting that it would be fairly difficult. Respondents believed that it would be slightly more difficult to obtain wine and spirits, with a larger number reporting that it would be fairly or very difficult, and fewer perceiving that it would be fairly easy or very easy.

Smoking

Participants were asked on how many occasions had they smoked cigarettes during their lifetimes. More than two-thirds of students reported that they had never smoked a cigarette and a further 10.4% had only smoked on one or two occasions. Eight per cent of all students reported smoking on at least 40 occasions. Overall, almost one-third had ever smoked in their lifetime (32.3%).

When students were asked to consider how often they smoked in the past 30 days, 87% reported that they had not smoked at all, while 13% had smoked at least once. Almost 7% of students reported smoking less than one cigarette per day and a further 5.7% smoked between one and 20 cigarettes per day. Ten students reported smoking more than 20 cigarettes a day. While the proportion of male and female students who had ever smoked was similar, there were gender differences in the intensity of smoking behaviours. More males reported smoking daily and smoking more cigarettes per day than females, while more female students smoked less frequently than every day.

Trends over time demonstrate that current smoking among school-aged children in Ireland is greatly reduced when compared to previous ESPAD surveys. This represents a reduction of over two-thirds (68%) since the first survey was conducted in 1995, and a 38% reduction over the previous four years (Table 2).

Table 2: Smoking in the past 30 days among 15–16-year-olds in Ireland since 2003

30-day cigarette use	2003 (%)	2007 (%)	2011 (%)	2015 (%)
Males	28	19	19	13
Females	37	27	23	13
All subjects	33	23	21	13

Source: ESPAD Ireland, 2016

Sixth ESPAD survey report published continued

Over 60% of students perceived obtaining cigarettes as either fairly easy or very easy, and male students believed it would be easier to access cigarettes than females. Most students believed that there is a moderate risk (34%) or a slight risk (30%) of smoking occasionally, and two-thirds answered that they perceived a great risk from smoking one or more packs of cigarettes per day.

Other substance use

Students were asked how many times in their lives had they used cannabis. Male students (22.4%) were more likely than females (15.5%) to have ever tried cannabis. Overall, 19% of students had ever tried cannabis, of which most had tried it once or twice. There was also a sizeable minority of students who smoked cannabis 40 times or more (3.9%).

Overall, 16.8% of students had used cannabis in the past 12 months. Again, more male (19.5%) than female respondents (13.9%) reported using cannabis in the past year. A small number of males (4.1%) reported using cannabis 40 times in the past year, suggesting heavier use than female respondents (1.2%). Boys were also more likely to have tried cannabis at a younger age than girls. Three per cent of boys and 1% of girls had first used cannabis at 12 years of age or younger. Most students had first tried cannabis at 14 years of age (33%) and 15% had first tried it at 13 years.

When respondents were asked how easy they thought it would be to obtain cannabis, 41.9% perceived that it would be impossible, very difficult or fairly difficult and 43.4% perceived that it would be fairly easy or very easy.

With regard to lifetime use of other substances, after tobacco, alcohol and cannabis, inhalants were the most commonly used substance at 10%. The next most regularly used drugs were painkillers 'to get high' (4%), ecstasy (3%) and tranquilisers (3%). In general, however, the prevalence of illicit drug use was low.

Trend analysis showed that lifetime use of cannabis in Ireland and other ESPAD survey countries stayed approximately the same, with a one-percentage point decrease for the ESPAD average and a one-percentage point increase for Ireland. For Ireland, this represents a drop of almost half since 1995, although lifetime prevalence of cannabis use has remained relatively unchanged at approximately 20% since 2007 (Table 3). In Ireland, there was an increase in the lifetime use of illicit drugs other than cannabis by one percentage point, increasing from 6% to 7%. Overall, however, there has been a 56% reduction since 1995.

Table 3: Percentage of 15–16-year-olds who reported lifetime use of drugs in the ESPAD Irish surveys of 2003, 2007, 2011 and 2015

Lifetime use	2003 (%)	2007 (%)	2011 (%)	2015 (%)
Cannabis	39	20	18	19
Illicit substances other than cannabis	9	10	6	7
Tranquilisers (prescribed)	10	10	9	11
Tranquilisers (non-prescribed)	23	3	3	3
Inhalants	18	15	9	10
Magic mushrooms	4	4	2	2
Ecstasy	5	4	2	3
Amphetamines	1	3	2	2
LSD	2	3	2	2
Crack	2	4	2	1
Cocaine	3	4	3	2
Heroin	1	1	1	0.4

Source: ESPAD Ireland, 2016

Current trends

In summary, results from the ESPAD 2015 survey suggest a decline in the use of alcohol and cigarettes among school-aged children in the Republic of Ireland. The use of cannabis, inhalants and other illicit substances may have stabilised, with an overall reduction over the six data collection waves from 1995 to 2015. Nevertheless, it should be noted that early school-leavers, a group known to be vulnerable to alcohol and drug use, are not represented in this survey. Consequently, the results may not indicate the true extent of alcohol and other illicit substance use among all 15–16-year-old children within Ireland.

Seán Millar

1 Taylor K, Babineau K, Keogan S, Whelan E and Clancy L (2016) *ESPAD 2015: European Schools Project on Alcohol and Other Drugs in Ireland.* Dublin: Department of Health. http://www.drugsandalcohol.ie/26116/

Trends in alcohol and drug admissions to psychiatric facilities

Data from *Activities of Irish psychiatric units and hospitals 2015*, the annual report published by the Mental Health Information Systems Unit of the Health Research Board, have shown that the total number of first admissions to inpatient care for persons with an alcohol disorder has continued to fall.[1]

In 2015, 1188 cases with an alcohol disorder were admitted to psychiatric facilities, of whom 437 were treated for the first time. Figure 1 presents the rates of first admission between 1995 and 2015. Trends observed since 1995 have continued, with a reduction in the rate of first admissions in 2015 compared to 2014. Just over 33% of all cases hospitalised for an alcohol disorder in 2015 stayed just under one week, while 28% of cases were hospitalised for between one and three months.

However, trends of first admissions for alcohol disorders contrast with those observed for patients with a drug disorder. Figure 2 presents the rates of first admission between 1995 and 2015 for drug disorder cases. In 2015, 1032 persons were admitted to psychiatric facilities with a drug disorder. Of these cases, 448 were treated for the first time, which represents a rate of 9.8 per 100 000 of population, the highest rate recorded since 1995. Since 2006, there has been a general increase in the rate of first admissions. It should be noted, however, that the report does not present data on drug use and psychiatric comorbidity, so it is not possible to determine whether or not these admissions were appropriate.

Other notable statistics on admissions for a drug disorder in 2015 include the following:

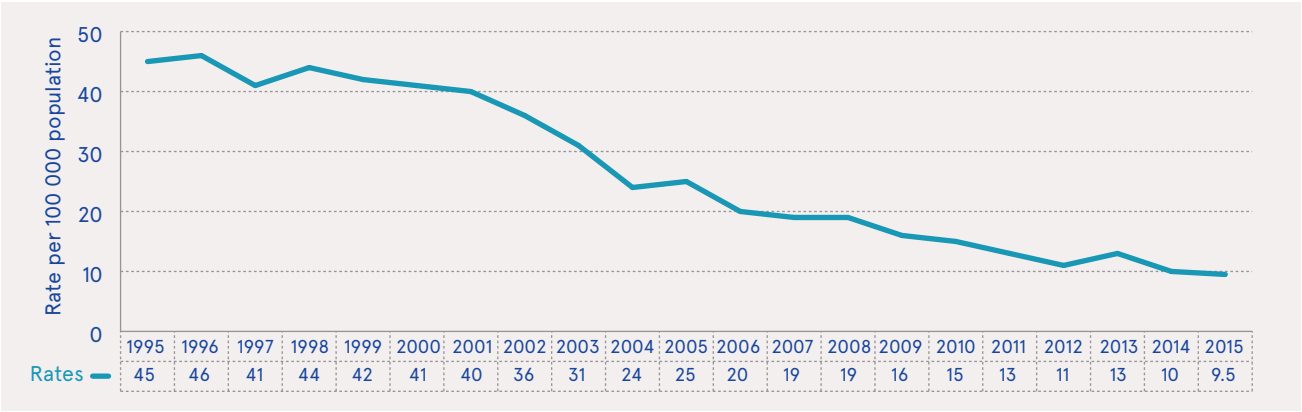
- Just under one-half (47.1%) of cases hospitalised for a drug disorder stayed less than one week, while 98% were discharged within three months. It should be noted that admissions and discharges represent episodes or events and not persons.
- 11% of first time admissions were involuntary.
- The rate of first time admissions was higher for men (14.2 per 100 000 of population) than for women (5.4 per 100 000 of population).

The overall increase in the rate of drug-related first admissions between 1995 and 2015 may reflect an overall increase in problem drug use within Ireland, and its increasing burden on psychiatric and mental health services.

Seán Millar

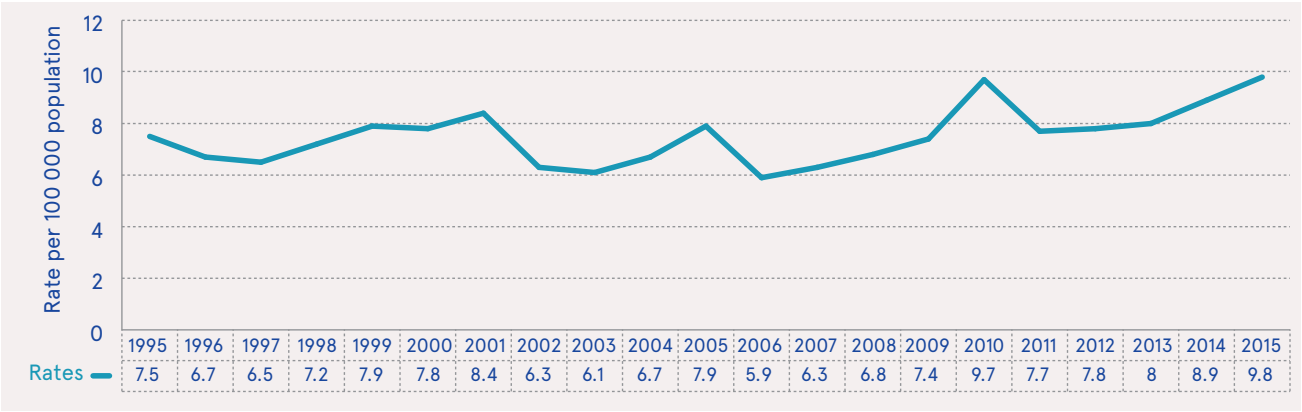
1 Daly A and Craig S (2016) *Activities of Irish psychiatric units and hospitals 2015.* Dublin: Health Research Board. http://www.drugsandalcohol.ie/25844/

Figure 1: Rates of psychiatric first admission of cases with an alcohol disorder diagnosis per 100 000 of population in Ireland, 1995–2015



Source: Daly and Craig, 2016

Figure 2: Rates of psychiatric first admission of cases with a drug disorder diagnosis per 100 000 of population in Ireland, 1995–2015



Source: Daly and Craig, 2016

Young people's views of substance use and parenting

The findings of a qualitative study that sets out to explore young people's perceptions of the mechanisms by which family processes protect or place youth at risk of substance use have been published. McLaughlin *et al.'s*[1] work was carried out with a view to informing family-based interventions preventing drug use. They held nine focus groups with a total sample of 62 participants aged between 13 and 17 years of age. Participants were post-primary school pupils from across Northern Ireland. While schools were selected from areas with a range of multiple deprivation measure rankings, data were not collected on individual pupil's socioeconomic status or personal experience of substance misuse. Therefore, the findings were based on hypothetical situations rather than participants' personal experiences. This limitation was explicitly acknowledged by the authors. Nonetheless, the findings included some useful insights that can be used to inform intervention development.

The authors identified three main themes in their analysis of young people's views of how family processes can protect or increase the risk of engaging in drug use: parent–child attachment; parenting style; and, parent and sibling substance use. In their discussion, McLaughlin *et al.* identified a number of messages for parenting interventions.

These include:

- Parenting programmes should emphasise ways to support positive attachments between parent and child. Programmes could educate parents on the importance of spending 'quality time' with their children and support them in improving their skills for communicating with their children.
- They should teach authoritative parenting styles and parental monitoring, ensuring participants have the skills to implement these at home.
- They should provide parents with the skills necessary to deal with the discovery or disclosure of substance use. These skills should include understanding effective discipline methods and dealing with any conflicts that might arise.
- They should generally take account of gender differences and the role they might play in parents' ways of communicating with young people and dealing with any substance use that may occur. The authors identified a particular need to work with fathers.
- They should educate parents about the effects of parental substance use on their children, while also targeting young people whose parents were substance users with a school-based programme. (Perceptions of the effects of parental substance use on their children were divided; in some cases, it was perceived to have a protective effect, while in others it increased the risk of use.)

The authors concluded that parenting programmes have a role to play in supporting families to develop the skills necessary to protect their young people from harm associated with substance use.

Lucy Dillon

1 McLaughlin A, Campbell A and McColgan M (2016) Adolescent substance use in the context of the family: a qualitative study of young people's views on parent–child attachments, parenting style and parental substance use. *Substance Use & Misuse*, 51 (14): 1846–1855. http://www.drugsandalcohol.ie/26088/

Second review of quality of crime statistics by CSO

In September 2016, the Central Statistics Office (CSO) published its second review on the accuracy of data collated on An Garda Síochána's PULSE (police using leading systems effectively) system.[1] The initial comprehensive review, published in 2015, was centred on data from 2011.

In Ireland, recorded crime statistics provide vital information regarding the frequency and type of crime that arises. However, in 2014, the Garda Inspectorate raised serious concerns regarding how crime was recorded on PULSE.[2] Issues included the non-recording of crimes, lack of timeliness in recording crimes, misclassifying crime incidents and non-crime incidents at initial stages, alterations of narratives, incorrect reclassification of incidents, and incorrect application of detection and invalidation status to certain crimes. Seeing that the CSO avails of PULSE data to produce crime statistics, it was considered pertinent to appraise the data received by the CSO to establish how accurate they were.[3] Although publication of crime statistics restarted following this review, the CSO decided that the data would need to be monitored on a regular basis. The aim of the second review was to determine whether issues raised in the first review still existed.

This analysis essentially retains the same methodology as the previous study.[3] However, there are two exceptions: sample sizes have been adjusted and the reclassification section involves a more detailed analysis. Access was provided by An Garda Síochána to crime and non-crime data including CAD (command-aided dispatch), paper records and non-crime PULSE incident groups, incident narrative audit trails, and reclassified incidents. A random selection of CAD and paper records was checked against corresponding records on PULSE.

Non-recording of crimes

In 2015, validated data for crimes (e.g. assault, burglary, criminal damage, public order, robbery, theft) that occurred in Dublin and in non-Dublin areas reported on CADs were not reported on PULSE, 17% and 18% respectively.

Second review of quality of crime statistics by CSO continued

In addition, the proportion of validated paper records (16%) not reported on PULSE were similar to the 2011 analysis. Matching records was challenging; hence, the authors advised caution when interpreting results as some records believed not to be on PULSE may in fact be within the system.

Lack of timeliness in recording crimes

Within the PULSE system a creation date and report date are recorded. In 2015, the CSO found that following a crime being reported, there was a delay of over one week before 6% of incidents were recorded on PULSE. Between crime categories, the delay ranged from a low of 1% (robbery, extortion and hijacking offences; burglary and related offences) to a high of 46% of offences against government, justice procedures, and organisation of crime.

Alteration of narratives

The narrative field on PULSE, which records details of a crime, can be amended as further information becomes available. To determine whether narratives had been edited to justify classification decisions, the narrative lengths of a random sample of PULSE incident records (n=995) were analysed to see if any reductions in length had taken place in 2015, which would indicate unacceptable editing. Four cases were identified, which was only slightly higher than the analysis in the previous report (n=1).

Misclassification of incidents

There are approximately 300 crime classifications on PULSE. Although the majority are crimes, non-crime classifications also exist (e.g. attention and complaints). How crimes are classified is essential for accurate reporting. Similar to the previous analysis, the CSO focused on six classifications of serious crimes – assault minor; assault causing harm; criminal damages (not arson); theft from person; burglary; and robbery from the person. The analysis indicated that 3% of records were classified incorrectly and the classification of a further 2% was unclear.

To determine whether non-crime incidents should have been classified as crimes, narratives from attention and complaints (n=1200), property lost (n=500) and domestic dispute (n=300) were examined. Although the majority of records were classified correctly (95%–98%), a small number of records were either misclassified (1%–3%) or unclear (1%–2%). Further analysis indicated that 35 records from attention and complaints should have been classified as assaults or fraud/public order offences and one each in child pornography and robbery; two property lost should have been in thefts; and six domestic disputes should have been in assaults or harassment. Nonetheless, the percentage misclassified had decreased since the 2011 analysis.

Incorrect reclassification of crime incidents

In order to carry out a more in-depth analysis, the CSO obtained audit trails for all crimes that had been reclassified by An Garda Síochána in 2015 (n=3500). From these audit trails, four areas were examined: assault causing harm and assault minor (n=233), criminal damage (n=224), arson (n=52), robbery from person or institution (n=28) and burglary (n=272). The analysis indicated that 68% of reclassifications were justified, while 32% were not. Reclassifications were upwards (more serious) or downwards (less serious), 24% and 48% respectively. Within crime classifications, a higher percentage of upward reclassifications occurred in the assault minor category (69%). The highest percentage of downward reclassifications occurred in the burglary (90%), arson (87%), assault causing harm (70%) and robbery from person/institution (61%) categories.

A further analysis of 'downgrades' in the burglary category indicated that 55% were justified and 45% were not. Primarily, unjustified downgrades in this category were for reclassifications for attempted burglary to trespassing or criminal damage categories. Similarly, in the robbery from person/institution category, 59% were justified and 45% were not.

In relation to crimes reclassified into non-crime categories, for example 6% of reclassifications in 2015 were to attention and complaints, which was lower than the estimate for 2011 (17%). However, the CSO advises caution when interpreting this result as the samples and methodology may not be comparable. Notably, three groups – Group 03 Attempts/ threats to murder, assaults, harassments and related offences; Group 10 Controlled drug offences; and Group 12 Damage to property and to the environment – accounted for the highest level of reclassifications to attention and complaints (11%).

Incorrect application of detection status

To determine whether 'detected' crimes resulted in criminal proceedings, 112 879 'detected' crimes were examined. Sixty-three per cent, which illustrated an increase since 2011 (54%), were linked to a charge or summons, whereas 37% were not. However, the CSO advises caution when interpreting this, as the 2011 and 2015 data may not be comparable. A further analysis of the accuracy of 'detection rules' on 'detected' crimes with no charge or summons (n=1000) indicated that nearly one-fifth of crimes were wrongly assigned 'detected' (18%), which was nearly half of those 'detected'. This accounted for a 10% (12 789) reduction in the total number of 'detected' crimes.

Incorrect application of invalidation status

Invalidation occurred when there was no crime or when 'counting rules' were wrongly applied (p. 28). Out of a sample of 1000 invalidated records in 2015, 21% were unjustified, which was slightly lower than 2011 (23%). Importantly, an unjustified invalidation does not mean a crime has not been dealt with correctly; often when a new case is created on PULSE, a previous crime linked to the same case becomes invalid due to lack of information.

Conclusions and recommendations

The CSO estimated the approximate impact of the problems identified in their review. The largest percentage changes in 2015 were:

- Group 13 Public order and other social code offences (50%)
- Group 03 Attempts, threats to murder, assaults, harassments and related offences (33%)
- Group 12 Damage to property and to the environment (32%)
- Group 11 Weapons and explosives offences (31%)

Alterations owing to misclassifications within groups were not considered; for example, assault causing harm and assault minor are both in Group 03.

Consistent with the Garda Inspectorate report and the previous analysis in 2011, the analysis carried out by the CSO on 2015 data illustrates that discrepancies between crimes recorded on CAD/paper and PULSE are ongoing. However, although there is evidence of non-recording of crimes on PULSE, it has to be acknowledged that crime misclassification on PULSE and inaccurate use of detection status has reduced since the previous report.

The CSO made a number of recommendations to further improve the quality of crime data.

- An area that requires immediate attention is the CAD narrative field, which should contain all necessary information about crimes prior to being closed, including a PULSE identity number (ID), and reasons for non-recording.
- RC1 forms need to be utilised in all non-CAD divisions.
- It is vital that Garda stations without an electronic recording system maintain proper paper records, including all crime information along with its associated PULSE record.
- Narratives on PULSE need to be more detailed such that information recorded supports crime classification applied and any subsequent invalidation/detection decisions that are made.
- To overcome quality issues that were delineated in this report, it is recommended that An Garda Síochána should put structures in place to ensure that crime-related data are monitored and controlled.

With the aim of increasing the reliability of the data, the CSO continues to collaborate with An Garda Síochána. Additionally, the CSO intends to continue monitoring the quality of the data by repeating this analysis on an ongoing basis.

Ciara H Guiney

1 Central Statistics Office (2016) *Review of the quality of crime statistics 2016*. Cork: Central Statistics Office. Available online at: http://www.drugsandalcohol.ie/26176/

2 Garda Inspectorate (2014) *Report of the Garda Síochána Inspectorate: crime investigation*. Dublin: Garda Inspectorate. Available online at: http://www.drugsandalcohol.ie/22967/

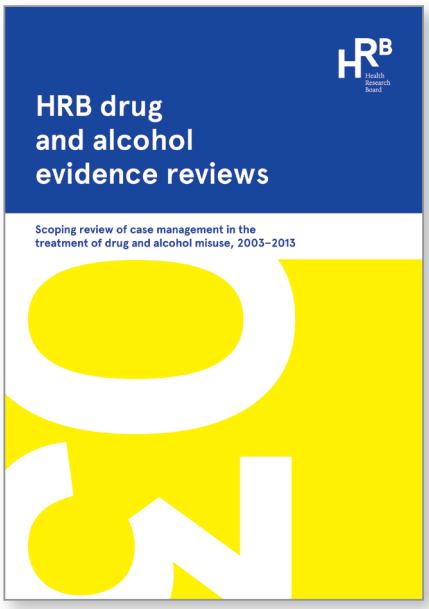
3 Central Statistics Office (2015) *Review of the quality of crime statistics*. Dublin: Government of Ireland. Available online at: http://www.drugsandalcohol.ie/24887/

RESPONSES

HRB drug and alcohol evidence review on case management

The objective of the HRB's recently published scoping review[1] was to examine the peer-reviewed non-experimental literature on case management and substance use published between 2003 and 2013, and to answer specific research questions based on the literature. These comprised questions on the nature of case management, the outcomes studied, and gaps in the literature.

In a case management approach to service provision, clients are typically offered and receive, or are linked to, a range of services tailored to meet their specific, individual needs. The objective of linking clients to relevant medical and social services is a key characteristic of this approach. Case managers also frequently work as advocates for their clients. This advocacy work may involve liaising with housing associations to address accommodation needs or job centres to improve employability. The rationale behind the linkage and advocacy work is that clients frequently present with multiple needs or complications which impact on their recovery or rehabilitation. Developing and maintaining links with existing services can help to address these multiple needs and aid the recovery process. Case management is also used to increase client retention in services and improve treatment outcomes.



Case management: models and roles

Vanderplasschen *et al.* identified six basic models following their review of the case management literature up to 2003.[2] These are outlined briefly below.

- **The brokerage model:** Case managers act as 'brokers', assisting clients to identify their needs and gain access to other services or supports; generally, it involves a brief engagement with clients with only one or two meetings.
- **Generalist models:** Case managers work with clients to identify needs and negotiate access to required services and supports; a longer-term and closer relationship with clients is developed over time.

Review on case management

continued

- **Assertive community treatment (ACT):** Case managers work in teams to help identify client needs and provide services directly to clients through assertive outreach.
- **Intensive case management (ICM):** Case managers work on a more intensive, individual basis with clients and usually have a lower caseload; they identify needs, provide services directly and link clients with relevant services.
- **The strengths perspective:** Case managers seek to empower the client to identify their own strengths to build on, rather than primarily focusing on correcting their deficits; this approach encourages the use of informal sources of support and help.
- **Clinical case management:** Case managers provide direct clinical input to clients and combine that with assistance in accessing other resources, particularly from the health and social care sector.

In recent years, the role of case management has been promoted in a number of important policy reports in Ireland, which include plans to improve service coordination for people in recovery from substance misuse. In 2007, the Report of the Working Group on Drugs Rehabilitation[3] made a number of key recommendations and set out the structural arrangements required to implement them. One of these was the development of broad national protocols to facilitate interagency working; these cover issues such as confidentiality, common assessment tools, referral procedures, and conflict resolution between agencies. In 2010, the Health Service Executive (HSE) published the National Drugs Rehabilitation Framework (NDRF), setting out how services to current and former drug users were to be provided in the form of supported integrated care pathways (ICPs) with the cooperation of different service providers. The report recognised that service users may present with diverse needs, such as treatment, education, vocational training, employment support and accommodation, and that no single agency can cater for all possible needs. An individual care plan for each service user needs to be delivered by a multidisciplinary team. Where a service user has complex and multifaceted needs, a more intensive case management approach may be used. The framework stated that the provision of rehabilitation pathways is a shared responsibility of the education, training and employment sectors alongside the health, welfare and housing sector, non-governmental organisations, communities, families, and the individual themselves.

The ICP comprises four steps, linked to the four-tier model of service provision: initial contact, involving screening and referral; initial assessment and identification of appropriate service; comprehensive assessment, following which a case manager is identified to support the individual on their rehabilitation pathway; and implementation of the care plan.

The HRB's scoping review was commissioned to examine the non-experimental research literature on case management and people in recovery from substance misuse. The objectives of the review were to explore the nature of case management as reported in the literature, document the outcomes associated with case management, and identify the gaps in the research literature. It is hoped that the report can be used by policy-makers and practitioners in Ireland to update their understanding and use of case management as an approach to improving service coordination and recovery.

In order to focus this review, three research questions were agreed at the outset:

1. What additional knowledge regarding the nature of case management can be gained from a review of recent non-experimental research on the topic?
2. What outcomes have been evaluated in the non-experimental research literature?
3. What are the gaps in the literature?

What additional knowledge regarding the nature of case management can be gained from a review of recent non-experimental research on the topic?

Case management interventions tend to target clients experiencing extreme disadvantage relative to other substance misuse treatment clients, with a disproportionate amount applying to females. The groups of people being targeted by case management present with a multitude of personal and social problems, including substance misuse, homelessness, economic deprivation and mental health problems.

From the literature reviewed, it would appear that there are multiple objectives of case management, including reducing substance misuse and visits to hospital emergency departments, reducing hospital admissions, and improving social and psychological functioning. In addition, there are a number of objectives reported in the literature related to improving service coordination, such as providing linkages with medical and social services and retaining people in treatment. The identification of such a broad range of objectives points to the multiple needs of the client base and the expectations on case management as an intervention.

The review identified a number of features of case management delivery that were associated with improved outcomes reported in the evaluations. These included that duration and intensity of the intervention could be an important variable to consider both in future planning and evaluation of case management. Team-based case management and extensive engagement by case managers with the client group are also associated with positive outcomes.

What outcomes have been evaluated in the non-experimental research literature?

Of the 20 evaluations included in this review, 13 examined outcomes under the broad heading of psychosocial functioning, which, after substance use, is the second most frequent type of indicator in these studies. Two of these evaluations – one on a combination of ACT and ICM, and the other on using a community-based case management model – had a particular focus on quality-of-life issues, and both studies showed improvements in these outcome domains. Only three of the 20 evaluation studies in the review did not find sufficient evidence to support the claim that case management contributed to improved outcomes in at least one area. The improved outcomes reported in these studies may well be associated with the use of case management,

or they may be due to unknown factors or influences which cannot be ruled out given the design of the evaluations reported. Only one-quarter of the evaluation studies used a comparison group; the rest of the evaluation studies used retrospective single groups and before-and-after designs.

What are the gaps in the literature?

Vanderplasschen *et al*. argue that there is a need to consider outcomes beyond drug use and other 'socially acceptable outcomes' and to take into account quality-of-life outcomes and clients' subjective perceptions when evaluating the effectiveness of case management. They also noted that there is little information on the crucial features of case management and what specific aspects of this intervention contribute to specific outcomes. This is exacerbated by the lack of fidelity in implementation and the distance between the model chosen and its practical application.

The review identified similar gaps in the literature as those reported by Vanderplasschen *et al*. As pointed out above, in the 20 evaluations included in this review, two broad categories of outcomes were evaluated. The predominant use of these hard outcomes to evaluate case management suggests an overemphasis on using case management as a deficit-reduction intervention. Indeed, there is almost a complete absence in the literature of the strengths-based case management model being used and evaluated. This type of model prioritises the empowerment of the client group by emphasising their strengths and would be more amenable to evaluating the softer outcomes that may be associated with improvements in quality of life.

This review also identified a major gap in the literature around any attempt to identify what specific aspects of case management contribute to improved outcomes. In essence, both primary and secondary studies sought to determine whether case management works for people in recovery from substance misuse; in the main these studies and reviews have produced some evidence to suggest that case management is an effective intervention to use with this target group. While such study designs are important in determining the efficacy and effectiveness of an intervention, the authors suggest that the evidence base would also benefit from an evaluation approach that seeks to understand not only does it work, but for whom and under what conditions and contexts. They suggest that the realist approach to evaluation and synthesis may be an appropriate approach to consider for researchers and reviewers to use in future investigations of case management.

The authors suggested earlier that certain features of case management identified in this review – notably the duration, intensity, the team-based nature of some of the work and the nature of the engagement between case managers and clients – could be important variables that require further elaboration and evaluation. Although their observations are based on a small number of studies, the authors reiterate the point here and suggest that these features and perhaps many more could be investigated using the realist approach. The realist approach is a theory-driven approach to evaluation and synthesis; it seeks to uncover the processes or mechanisms that lead to particular outcomes, and the context within which this occurs.

A recent review in 2014 by Jackson *et al*.[4] provides a useful example on how the realist approach may elucidate important learning about case management in future investigations.[4] This is a realist review and the methods used enabled the authors to draw certain conclusions about why an intervention may work sometimes and under what conditions. Its exploration of the literature in the area suggests that engagement with an intervention appears to be key to its success.

It could well be hypothesised that engagement is also a key mechanism that is associated with improved outcomes in clients of case management, for example, when the intervention is intensive, of longer duration, accompanied by a good working alliance between the case manager and client and with dedicated care plans. These components could well contribute to the client engaging with the intervention and 'investing' in their recovery and accruing some benefits. Further evaluation and synthesis of case management with people in recovery from substance misuse are needed to investigate the role of these potential features of case management in delivering improved outcomes for clients.

Brian Galvin

1 Nic Gabhainn S, D'Eath M, Keane M and Sixsmith JA (2016) *Scoping review of case management in the treatment of drug and alcohol misuse, 2003–2013*. HRB Drug and Alcohol Evidence Review 3. Dublin: Health Research Board. http://www.drugsandalcohol.ie/26681/

2 Vanderplasschen W, Wolf J, Rapp RC and Broekaert E (2007) Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs,* 39(1): 81–95.

3 Working Group on Drugs Rehabilitation (2007) *National Drugs Strategy 2001–2008: rehabilitation. Report of the Working Group on Drugs Rehabilitation, May 2007*. Dublin: Department of Community, Rural and Gaeltacht Affairs. http://www.drugsandalcohol.ie/6267/

4 Jackson LA, Buxton JA, Dingwell J, Dykeman M, Gahagan J, Gallant K, Karabanow J, Kirkland S, LeVangie D, Sketris I, Gossop M and Davison C (2014) Improving psychosocial health and employment outcomes for individuals receiving methadone treatment: a realist synthesis of what makes interventions work. *BMC Psychology,* 2(1): 26.

Launch of the Evaluation of the HSE Naloxone Demonstration Project

On 30 August 2016, Minister of State for Communities and National Drugs Strategy Catherine Byrne TD attended the launch of the *Evaluation of the HSE Naloxone Demonstration Project* in Temple Bar, Dublin.[1] The external evaluation was commissioned by the HSE National Social Inclusion Office and its launch coincided with International Overdose Day. The key theme was 'Time to Remember, Time to Act', which acknowledged the trauma and suffering of families and friends affected by drug misuse. The aim of the day was to reduce the stigma of drug-related deaths and to spread the message that overdose death and injury is preventable.

Background

In Europe, between 6000 and 8000 deaths by overdose are reported annually with the majority as a result of heroin or opiate overdose.[2] In Ireland, based on figures reported in the National Drug-Related Deaths Index (NDRDI) for 2013, opioids were implicated in 203 deaths, representing 58.2% of the total number of poisonings that year.[3] A principle finding in this data was that 42% of these individuals were not alone at the time of death. This indicated that an appropriate intervention, such as the administration of an opioid reversal agent like naloxone, could have potentially saved those lives.

Naloxone is a semi-synthetic drug used to temporarily alleviate the physiological symptoms of opiate overdose. It is listed by the World Health Organization as a specific antidote and was included on the *Model list of essential medicines* in 2013.[4] Administered intravenously, intramuscularly or by nasal spray, naloxone temporarily reverses the respiratory depression experienced during an overdose, providing a life-saving period before emergency services arrive for further medical intervention.

Naloxone Demonstration Project

Under Action 40 of the current *National Drugs Strategy* and addressing the four tiers of the Rehabilitation Pathway of the National Drugs Rehabilitation Implementation Committee (NDRIC),[5,6] the purpose of the HSE Naloxone Demonstration Project was to test the feasibility of making naloxone available to prevent death from overdose. The first part of the project involved formal briefing and training of drug users and those close to them (including service providers, front-line workers, family members, and friends) on how to use naloxone and how to recognise and manage overdose events. The second part involved prescribing naloxone kits to 600 opioid users in Dublin, Limerick, Cork and Waterford following training. The naloxone kits were single, individual use prepacked syringes containing five doses of Prenoxad® (1 mg/ml injection). Intramuscular administration of naloxone was used as no intranasal device has yet been approved for the European market.

Over a two-year preparatory period, a quality advisory group (QAG) was established to oversee the implementation of the project and extensive input was sought from a number of different stakeholders.[7] A cascade-style training model for the project was agreed and comprehensive training materials and resources were developed. The project formally commenced in February 2015 and the external evaluation began in June 2015, involving action research which continued until October 2015. A process evaluation was carried out to analyse the content and quality of the training programme, and to gather feedback from training participants. In addition, an outcome evaluation of the training was conducted, and the effect of the practical application of naloxone and harm-minimising techniques to reduce the number of fatal overdoses was investigated.

An open invitation was sent to all relevant services to take part in the naloxone and overdose training alongside the implementation of a programme to increase awareness of the project in potentially interested stakeholders, e.g. homeless services, National Family Support Network (NFSN). Thirty-one people took part in a train-the-trainer programme, one-third of whom cascaded the training programme across the four demonstration sites. By October 2015, close to 600 people had received the naloxone and overdose training, comprising a diverse group of general practitioners (GPs), pharmacists, front-line workers, HSE and Irish Prison Service personnel, opioid users, family members and outreach workers.

Attending the launch of the *Evaluation of the HSE Naloxone Demonstration Project*, Mr Tim Bingham and Minister of State for Communities and the National Drugs Strategy, Catherine Byrne TD

HSE Naloxone Demonstration Project continued

Results of evaluation

Each participant completed a survey before and after the training. The results revealed significantly increased understanding and awareness of how to recognise and manage an opioid overdose event and the steps taken to administer naloxone appropriately. In total, 95 naloxone prescriptions were issued during the project by six GPs; the majority (67%) of prescriptions were in Dublin and the remainder (33%) in Limerick. As the project ended, another GP began prescribing naloxone in Waterford, as did the Drug Treatment Programme in the Irish Prison Service at Mountjoy Prison, Dublin. There were five separate overdoses during the project and in each case naloxone was administered in accordance with the predefined procedure. Four of these administrations were carried out by a front-line worker and the fifth was peer-to-peer. Notably, each naloxone kit was administered to a person other than for whom it had been prescribed. The evaluation found that the project successfully minimised the number of potentially fatal overdoses in Ireland between February and October 2015[8] and concluded that widespread accessibility and availability of naloxone was crucial to its life-saving function in the community.

Post-overdose event interviews were conducted, which showed that those who administered the naloxone felt pride and relief in their contribution to saving a life. Being armed with a tool to use in the event of an overdose situation provided these individuals with increased confidence and a sense of empowerment.

Although four demonstration sites were initially included in the project, no prescriptions were issued in Cork. The factors which improved uptake in the other demonstration sites were listed as increased prior knowledge of and interaction with the project; availability of local champions; belief in the efficacy of naloxone; clear communication of the process and referral pathways; acceptance, willingness and availability of GPs locally to engage and prescribe naloxone from the outset; and support from the NFSN and its membership on the ground.

Recommendations

The evaluation recommended the national implementation of the demonstration project in a managed, phased and strategic manner. This process will demand intense logistical coordination and specific areas of the project will require revision and reworking. The evaluation provided six key recommendations centred on 'communication, consultation, training design, robust research and planning for future roll out and distribution of naloxone in Ireland' (p. 57).[1]

1 Improved communication is required on a national level. Feedback should be given adequate consideration in advance of an all-Ireland rollout of the scheme.

2 The governance of the QAG should be strengthened and membership extended to include clinical expertise and regional representation.

3 Naloxone should be rolled out in Ireland in a measured, phased and strategic manner with a focus primarily on the Waterford/South East and Cork region. Dedicated staff and resources should be assigned to coordinate this process efficiently.

4 The training programme should be accredited by an appropriate body and should incorporate the learning from the evaluation. In addition, the programme should be flexible and constantly evolving to incorporate future feedback from participants, changes in legislation and product availability.

5 The briefing of opioid users, family members, friends and front-line workers should be continually monitored carefully and supported. In particular, the opioid users receiving the naloxone prescriptions should be given special attention, where health, well-being and drug-related behaviour are tracked over time.

6 Multidisciplinary research with a focus on clinical governance should take place relating to naloxone in Ireland. This research should be overseen by the QAG.

In terms of health economics, the project represented a good return on investment (€62,500) for the HSE. The demonstration project was responsible for the widespread training of opioid users, service providers and a wide range of other organisations about the threat of overdose and the potential of naloxone to save lives.

It has removed some of the stigma associated with drug misuse and provided people with a powerful life-saving, harm-minimising tool for use in overdose situations.

The evaluation highlighted the positive effects of naloxone as a 'catalyst for positive change in behaviour in drug use and harm minimisation' (p. 52). The authors felt that the demonstration project was well received in Ireland among the family members and front-line workers, and was deemed a success. In addition, given the approval of an intranasal formulation of naloxone by the US Food and Drug Administration in 2015, it is possible that the use of this device may be incorporated into new legislation in Ireland once a European equivalent becomes available.

Thérése Lynn

1 Clarke A and Eustace A (2016) *External evaluation of the HSE Naloxone Demonstration Project.* Dublin: Health Service Executive (HSE). http://www.drugsandalcohol.ie/26037/

2 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2015) *European Drug Report 2015: trends and developments.* Luxembourg: Publications Office of the European Union. http://www.drugsandalcohol.ie/24029/

3 Health Research Board (2015) *Drug-related deaths and deaths among drug users in Ireland: 2013 figures from the National Drug-Related Deaths Index.* Dublin: Health Research Board. http://www.drugsandalcohol.ie/24676/

4 World Health Organization (WHO) (2013) *WHO model list of essential medicines.* 18th edn. http://www.who.int/medicines/publications/essentialmedicines/en/

5 Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016.* Dublin: Department of Community, Rural and Gaeltacht Affairs. http://www.drugsandalcohol.ie/12388/

6 Department of Community, Rural and Gaeltacht Affairs (2007) *National Drugs Strategy 2001–2008: rehabilitation.* Dublin: Department of Community, Rural and Gaeltacht Affairs. http://www.drugsandalcohol.ie/6267/

7 Consultation took place with 'key stakeholders within the Department of Health, Health Products Regulatory Authority (HPRA), National Family Support Network (NFSN), voluntary support network, Irish Prison Service (IPS), Ana Liffey Drug Project (ALDP), Merchants Quay Ireland (MQI), National Drugs Rehabilitation Implementation Committee (NDRIC), SafetyNet, Primary Care, Pre-Hospital Emergency Care Council (PHECC) and the HSE Addiction Services'. (p. 27).

8 A further three overdose events and naloxone administrations occurred between November 2015 and January 2016.

New psychoactive substances in Europe conference, Poznan

On 26–27 October 2016, the Polish Reitox Focal Point and National Bureau for Drug Prevention held a conference on new psychoactive substances (NPS) in Europe. The conference opened with an overview of EMCDDA and the EU Early Warning System (EWS), which monitors and responds to new drugs or trends in drug use. Information is fed into the EU EWS by national focal points; this information exchange can trigger the preparation of joint reports and a formal risk assessment process followed by control measures as required.

There have been over 600 NPS notified to the EMCDDA and, of these, approximately two-thirds have been notified since 2012. The biggest group of NPS is synthetic cannabinoids followed by cathinones. Synthetic benzodiazepines and synthetic opioids have recently emerged, including extremely potent synthetic fentanyls. There is no sign of a decrease in this flow of new drugs with 98 new psychoactive substances reported in 2015. While approximately 250 of these drugs are internationally controlled, the rest are not.

'Chasing the white rabbit'

The analogy 'chasing the white rabbit' described a common theme throughout many presentations, namely, legislation introduced to ban NPS has driven the production of new substances, some worse than the originally banned substances. While 'brick and mortar' shops selling NPS have been largely eliminated, the market has simply moved online. Chinese manufacturers of NPS are reportedly capable of creating any drug upon request, including providing the precursor if desired, packaging and describing the product in any way requested, and advising on additional protective measures and new ways to transport.

The 2016 *EU drug markets report* states that:

> Globalised supply chains and the internet play a major role in driving the availability of new substances in Europe. Underpinning this growth is the ability to order bulk quantities of new substances from companies in China and to transport them rapidly to Europe by air or sea. Actors in the EU then package and market them either on the open market or directly on the illicit drug market.[1]

The near-impossible task of stemming the flow of NPS in the current globalised world was highlighted by Polish Customs officials, citing the enormous volumes of imports annually, extensive borders, increased flights, increased shipments, and millions of Customs declarations (often impossible to decipher). Misdeclarations are also common. The huge variety of NPS drugs and the rapid emergence of replacements when substances are banned cause difficulties in securing convictions for police across Europe, especially since a seizure may, after analysis, prove to be a non-controlled substance. Sanctions for the production and trafficking in NPS available to authorities in Poland include financial and administrative as well as penal sanctions.

Risk assessment and safety

At EU level, scientific risk assessment is separated from political decision; however; it is not possible to deal with the current numbers of NPS through this system and a three-stage assessment process is being progressed. The use of *precautionary-based* policies, adopted in a number of countries, as opposed to *evidence-based* policies (risk assessment) was discussed, posing the question 'Are we doing the right thing?'

Information about safe doses and risks associated with NPS should be provided to NPS users as a harm reduction measure. Also, medical staff need to be better informed so they can best treat emergencies. The EMCDDA recommended the development of hospital emergencies data as an instrument to be included in routine reporting.[2] In Poland, medical staff are required to report all NPS intoxications centrally, and this information is submitted to the Ministry of Health. Collated data can quickly alert authorities to dangers, such as the introduction of a new substance on the market. The health indicator monitored in Poland is medical interventions per 100 000, which reached 7284 in 2015, including 1627 in the 16–18 years age group and 2817 in the 19–24 years age group. The highest users of NPS are 19–24-year-olds (who were initially exposed to these substances as teenagers from 2008 onwards).

Peaks in intoxications occurred prior to planned legislative changes, when suppliers offered sales and promotions on products about to be banned. Suppliers immediately responded to bans with a range of new substances and promotions, such as offering free samples as 'testers'. In Poland, deaths attributed to NPS increased from 3 in 2013 to 22 in 2015. In Estonia, the main problem drugs are fentanyls (in Talinn) and amphetamines (in Narva). Drug-related deaths in Estonia decreased from 170 in 2012 to 88 in 2015. This is attributed to the naloxone programme introduced in 2013; 1336 personnel have been trained in the use of naloxone to treat opioid overdose, including 1054 drug users.

Research and information gathering

The need for better ways to monitor and gain insight and understanding of NPS users was advocated throughout the conference. This is regarded as essential in order to elucidate the attraction of these drugs and thereby help prevent social harm. Different aspects of information gathered by the I-TREND project carried out in several European countries were described.[3] This multifaceted project included:

- Automated analysis of online shops using a prototype software acting as a 'robot' trawling forums[4]
- Purchase and analysis of NPS online (The most reliable sources for online purchase were in the UK.)
- Survey of online users to identify motivations of NPS users and circumstances of use
- Analysis of national preferences

The survey of online NPS users found 72% were males aged 15–24 years, most were in education, living in cities and polydrug users. The reason(s) for taking these drugs included to socialise (53%), get high (51%), modify perception (47.5%), relax (32.5%), and personal curiosity (44.5%).

New psychoactive substances conference continued

Further research was presented based on analysis of 1 281 660 posts from internet forums identifying the motivation of users, the context of NPS use (where used and with whom), substance trajectories, and characteristics of users. NPS users were then categorised as six different types: scientist experts; experimenters; kami-kase cyborgs; novices; superman; or partygoers.

The need for a change of attitude towards drug users was also advocated. It was argued that since it will never be possible to reduce drug use to zero, rather than penalising users, a better approach would be to promote a healthy lifestyle in the same way that alcohol and tobacco use are addressed.

Collaboration and sharing of analytical information

Collaboration and sharing of analytical information was the final theme explored. European data-sharing initiatives include:

- EMCDDA's European Database on New Drugs (EDND): This is under redevelopment to improve information and searchability of the database. A pilot will launch in 2017.
- EU Joint Research Centre Directorate: Cloud spectroscopy for identification and monitoring of new psychoactive substances aims to provide fast recognition of NPS[5] and unknown chemicals, harmonised analytical methods, investigation of fast screening with handheld device and electronic repository of nitrogen/phosphorus detector data.

A challenge in compiling and sharing data is that chemical data are formatted differently in various databases with a wide range of vendor-specific formats for each drug, proprietary spectra formats, and complex data streams. There is also a need for a unique way to unambiguously name compounds, as current systematic chemical naming protocols can give several variants to the same molecule.

Siobhan Stokes

1 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2016) *EU drug markets report.* Luxembourg: Publications Office of the European Union. http://www.drugsandalcohol.ie/25357/

2 EMCDDA (2016) *2016–18 strategy and work programme and 2016 annual work programme.* Available online at http://www.emcdda.europa.eu/publications/work-programmes-and-strategies/2016-work-programme

3 For more information on I-TREND, visit http://www.i-trend.eu/

4 Open source software is available online at https://github.com/I-TREND/SASF

5 European Commission (2016) *Fostering the detection of 'legal highs'.* Available online at https://ec.europa.eu/jrc/en/news/fostering-detection-legal-highs; *Systematic analytical characterization of new psychoactive substances: a case study.* Available online at https://ec.europa.eu/jrc/en/publication/systematic-analytical-characterization-new-psychoactive-substances-case-study

Stop Out of Control Drinking campaign

The Diageo-funded 'responsible drinking' campaign named Stop Out of Control Drinking (SOOCD) was launched in February 2015 and chaired by Fergus Finlay, the chief executive of Barnardos. Since its inception, it has generated controversy due to its funding by the alcohol industry, and it has been claimed that it is merely a smokescreen to take away political focus from reforms in the Public Health (Alcohol) Bill 2015 around minimum pricing, marketing, alcohol promotion and alcohol availability.[1] A recent study analysed the SOOCD campaign. Its aims were to identify how the campaign and its advisory board members frame and define alcohol-related harm and its causes, and possible solutions.[2] This involved undertaking an analysis of SOOCD campaign material, which included newspaper articles (n=9), media interviews (n=11), Facebook posts (n=92), and Twitter tweets (n=340) produced by the campaign and by board members.

SOOCD board members

Initially, there were 17 board members, although four subsequently resigned, including David Smith, Diageo Ireland country director. A number of the remaining board members or their organisations have links to Diageo/Guinness. Gavin Duffy worked as an alcohol industry consultant and for Guinness; Sport for Business has Guinness as a client; Dublin City University has received Diageo funding; the Irish Rugby Union Players Association (IRUPA) is sponsored by Diageo; and Fergus Finlay is a mentor to the Arthur Guinness Fund supporting social entrepreneurs. It was not possible to ascertain if board members had any links to other alcohol companies. The campaign itself was supported by public relations firm Goddard Global, which has had both Diageo and tobacco companies as clients and is linked to the Common Sense Alliance, a tobacco industry lobby group.

Framing the problem

Although the campaign focuses on 'out of control drinking', what this means is not clearly defined. The authors found that the campaign used vague or self-defined concepts of 'out of control' and 'moderate' drinking, presenting alcohol harm as a behavioural problem rather than a health issue. There was no attempt to quantify moderate drinking, while one board member described the internationally public health measure of binge drinking as being 'unhelpful'. Some board members stated that moderate drinking is normal, and identified not drinking as abnormal; several also stated that critics of the campaign are non-drinkers and prohibitionists.

In relation to alcohol-related harm, the campaign emphasised antisocial behaviour; in contrast, the health harms associated with alcohol were almost entirely absent from discussions, even though alcohol-related health harm in Ireland is considerable. The focus was on young people, particularly young women, despite alcohol harms affecting men, women and children across the whole population. It was the opinion of the board members that the main causes of excessive drinking in young people were individual attitudes and motivations; Irish culture, tradition and society; and peers and parents.

Stop Out of Control Drinking campaign continued

They also highlighted that it is individuals themselves that are responsible for creating the Irish drinking culture, and they appeared to absolve the alcohol industry of any responsibility towards the creation or maintenance of this culture. In some cases, the responsibility of industry is explicitly excluded as an influence by board members.

Framing the solutions to 'out of control drinking'

Similar to the alcohol industry, board members focused on dealing with alcohol misuse, particularly in young people, rather than looking at alcohol as an issue for the general population. Board members generally did not recommend evidence-based population-based approaches, such as alcohol marketing restrictions, minimum unit pricing, and restrictions on availability. Conversely, they placed strong emphasis on educational interventions which are widely accepted as being ineffective. The need for evidence in dealing with the problem of 'out of control' drinking is mentioned, but scientific evidence is just one aspect to be considered alongside views, conversations, stories and experiences.

The authors conclude that the content of the SOOCD campaign reflects the needs of the alcohol industry rather than public health. They suggest that the main effect of the campaign may be to protect the reputation of Diageo in Ireland, while undermining the recent Public Health (Alcohol) Bill.

The current status of the campaign is unclear. Initially, it was intended to last for five years; however, social media activity appears to have ceased, and the SOOCD website is currently inaccessible (access attempted 20 October 2016).

Deirdre Mongan

1 Ó Fátharta C (2015) Third group steps down from Diageo alcohol campaign. *Irish Examiner* 25 Mar 2015. Retrieved 20 October 2016 from http://www.irishexaminer.com/ireland/third-group-steps-down-from-diageo-alcohol-campaign-320271.html.

2 Petticrew M, Fitzgerald N, Durand MA, Knai C, Davoren M, Perry I (2016) Diageo's 'Stop Out of Control Drinking' campaign in Ireland: an analysis. *PLoS One,* 11(9): e0160379.

An Garda Síochána Policing Plan 2016

An Garda Síochána Policing Plan 2016 identifies the policing commitments for 2016.[1] The focus of the plan is to protect communities and individuals in Ireland from risk and harm connected with crime, drugs, and domestic-related crime (e.g. burglaries and domestic violence). A number of areas have been identified as priorities for An Garda Síochána in 2016: national security and intelligence; national policing; community safety; and cross-organisation services.

National security and intelligence

The key objective of this priority is to defend the interests of Ireland in alleviating threats from terrorists by implementing a number of strategies, such as the International Counter-Terrorism Strategy, Cyber Security Strategy, and the joint Cross-Border Policing Strategy. In addition, the development of partnerships with policing and security organisations in Ireland and oversees will enable An Garda Síochána to contribute to worldwide security. Renewed attention will be placed on the management of intelligence and will result in the establishment of intelligence management systems in units nationwide. In preparation and in alignment with the framework for major emergency management, a strategy will be put forward to ensure that Ireland is ready for major emergencies should they arise. A contribution will also be made to the National Major Emergency Response Group.

National policing

The overall aim of the Irish policing service is to prevent all types of crime, for example organised and cross-border crime, which includes human trafficking, prostitution, burglary, drug-related crime, white collar crime, and crimes against business and agriculture. Domestic and sexual violence and crimes against children will continue to be targeted and investigated by An Garda Síochána. In order to provide enhanced protection for children, tools for risk assessment and risk management frameworks will be developed. This will allow Gardaí to identify the level of risk to which victims of sexual and domestic violence are exposed.

With the aim of averting and exposing crime, national anti-crime strategies, such as Operation Thor, will continue to play an important role in reducing crime. The investigation of crimes will be reinforced by the ongoing development and implementation of IT systems, such as the major investigations management system (MIMS).

The intention is to make victims of crime the focus of policing services, which is in alignment with the EU Directive on Victims Rights[2] and the Criminal Justice (Rights of Victims) Bill.[3] The ability to respond and manage incidents will therefore be developed by:

- enhancing computer-aided dispatch (CAD)
- developing strategies in the control room with the aim of improving service and contact response rates with the public, and
- being more efficient in the capture, collation and review of data collected.

Interagency collaboration is viewed as an essential component of addressing and managing repeat offending, and includes ongoing development of the Garda Juvenile Diversion Programme, implementation of the Strategic Approach to Offender Recidivism (SAOR) and the Joint Agency Response to Crime (J-ARC) initiative.

An Garda Síochána Policing Plan 2016 continued

Community safety

The *Policing Plan 2016* seeks to build on public safety by setting out a new community policing framework and a new crime prevention strategy. The intention is to avail of 'local policing fora' and joint policing committees (p. 9). Additionally, another priority is to build positive partnerships with community groups that may be diverse, at risk or difficult to reach. The aim is for Gardaí to be more visible within the community, which should result in greater detection and prevention of public disorder, antisocial behaviour, and illegal consumption of alcohol in public places. In order to improve communication, the Garda Communications Strategy, which aims to improve communication within the organisation, the State and the general public, will be implemented.

Safety on Irish roads is also targeted. Enforcement and education are viewed as important contributors to increasing safety on roads and within communities. Recommendations put forward by the Garda Inspectorate in their report on fixed charges will result in greater efficiency and more accountability.[4] Additionally, it has been proposed to implement more automatic number plate recognition (ANPR) technology, as this will allow Garda to 'track and target' offenders (p. 9).

Cross-organisation services

The final objective of the *Policing Plan 2016* is to ensure that resources used in the delivery of a professional policing and security service are effective and efficient. The main objectives to be delivered include:

- Optimising the development and deployment of skills and human resources across the organisation. This will include delivery of a Human Resource and People Development Strategy, revising recruitment, selection and internal appointment procedures as well as the identification and implementation of technology suitable for monitoring performance and development.
- Developing strong governance and leadership throughout the organisation. The goal is to develop and implement a corporate governance framework delineated in accordance with best practice. Additionally, other initiatives to be applied include standardised approaches for the performance and accountability framework (PAF), the Garda transformation programme, performance management systems, inspection and review processes, policy frameworks, and risk management.
- Instilling a culture of continuous improvement via education, training, and development. The aim is to determine how the core vocational and operational training is to be strategically measured and quantified with a view to evaluating how they compare with the current continuous professional development structures already in place.
- Identifying the core functionality of the service in order to make bureaucratic processes easier and thus moving towards leaner administrative systems.
- Working in partnership with the Garda Inspectorate, Garda Síochána Ombudsman Commission (GSOC) and the Policing Authority to implement recommendations and feedback.
- Addressing effective management of expenditure by targeting how financial resources are managed to support policing, fleet investment, and tenders for outsourced services (e.g. medical, uniforms, construction of two facilities for evidence and property).
- Working in partnership with local, national and international agencies, including academia and agencies, will increase collaboration resulting in stronger connections with partner agencies.

Although the *Policing Plan 2016* outlines numerous changes and areas for development, Garda Commissioner Nóirín O'Sullivan argues that 'policing [in this way] will be delivered differently with the aim of providing the country with a world class police service. But what won't change is An Garda Síochána's unstinting commitment to protecting communities and this State' (p. 4).

Ciara H Guiney

1 An Garda Síochána (2016) *An Garda Síochana Policing Plan 2016*. Available online at http://www.drugsandalcohol.ie/25794/

2 Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA. Available online at http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32012L0029&from=EN

3 The Criminal Justice (Victims of Crime) Bill (unpublished). Relevant Dáil debates available online at http://oireachtasdebates.oireachtas.ie

4 Garda Inspectorate (2014) *Report of the Garda Síochána Inspectorate: crime investigation*. Dublin: Garda Inspectorate. Available online at http://www.drugsandalcohol.ie/22967/

Club Health 2017 conference to be held in Dublin

The 2017 Club Health International Conference on Nightlife, Substance Use and Related Health Issues will be held in Dublin Castle from 24 to 26 May 2017.[1] This will be the 10th Club Health conference and the first to be held in Dublin. Club Health conferences bring together experts from a wide range of fields to meet, present and exchange information on the latest research, policy and practice on protecting and promoting health in urban night-time settings, music festivals and holiday destinations with a clubbing or nightlife focus. Professor Mark Bellis and Dr Chris Luke, in collaboration with HIT, the groundbreaking harm-reduction organisation, established Club Health in Liverpool in 1997. This was in response to the harm-reduction and health-promotion challenges of that city's night-time economy. The first conference was held in the city's very popular nightclub, Cream, and was prompted initially by the health and crime consequences that came with this popularity.

Global conference

Club Health has grown since 1997 to become a global conference that attracts a diverse range of expert international speakers and multidisciplinary participants, such as academics, researchers, club owners and clubbers. Club Health conferences have been held biennially since 1997, organised primarily by the Public Health Institute in Liverpool John Moores University, in partnership with host organisations, government departments and agencies in many countries. These include the Netherlands, Italy, Australia, Slovenia, Spain, the Czech Republic, Switzerland, the USA and, in 2015, Portugal.

Dublin bid

Following the 2015 Lisbon conference, a small group began working on a bid for the conference to be hosted in Dublin City in 2017. Meetings and consultations were held with key stakeholders to explore the interest and supports available to plan and deliver a successful conference and the potential topics and issues it might focus on. Through these meetings, it emerged strongly that the proposed conference in Ireland would be timely and welcome; it was especially pertinent, as the new National Drugs Strategy will be launched in 2017. Given the range and interdisciplinary of participants, speakers and topics at previous conferences, it also resonated with policy developments arising from the National Sexual Health Strategy[2] and results in the 2014 Flash Eurobarometer survey of young adults aged 15–24 in EU member states.[3] These were in relation to new psychoactive substances (NPS) consumption and use in Ireland as well as discussion of the Public Health (Alcohol) Bill 2015. With the enthusiastic support of stakeholders – such as the Health Research Board; Dublin City Council; UCD School of Social Policy, Social Work and Social Justice – and onsite visits to potential venues, the conference bid was successful, and awarded to Dublin in March 2016.

The conference in Dublin is expected to attract around 300 participants from across Ireland and the globe. It aims to build capacity and knowledge among all professionals and sectors with a stake in a healthy nightlife, including municipal and state policy-makers, public health planners, medical and nursing practitioners and scientists, drug and alcohol addiction service providers, criminologists, local authorities, transport sector and government agencies, representatives of the various nightlife industries, and, most importantly, citizens and customers using or affected by the night-time economy. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a key partner in the Dublin conference and will be presenting aspects of their current and relevant research at the event.

Networking is an important feature of all Club Health conferences. Previous conferences have developed and enhanced a powerful interdisciplinary international network of academics and practitioners, resulting in European and international research and practice collaborations with further similar alliances expected to emerge from the Dublin 2017 event.

Issues and topics

There will be many significant issues and topics explored in the conference. These include drug legislation and drug law reform; emerging trends in club culture; forensic testing of drugs or 'pill testing' and 'early warning systems'; health and safety standards for nightlife environments; harm-reduction interventions in nightlife settings; NPS; nightlife legislation, policy and economic impact of measures such as 'lock out laws' and night mayors; policing in the nightlife settings and in nightlife tourism destinations, such as Dublin's Temple Bar; sexual health and risk-taking sexual behaviours; violence in a nightlife context; social exclusion – or nightlife without money; and other cutting edge and emerging relevant topics.

The Club Health Dublin 2017 conference will be held in the Printworks in Dublin Castle, 24–26 May. It promises to be a stimulating, engaging, diverse and comprehensive event, assessing and debating what works to make the nightlife environment heathier, economically viable, and safer. And all this without losing core focus on the essential fun, dynamic and vibrant elements of a good night out. The call for abstracts and poster presentations is open via the Club Health Dublin website, where registration details and further information on the event and how to participate can also be found.

Siobhán O'Brien Green

1 For more information on Club Health 2017, visit http://theclubhealthconference.com/

2 Department of Health (2015) *National Sexual Health Strategy 2015–2020 and action plan 2015–2016*. Dublin: Department of Health. http://www.drugsandalcohol.ie/24714/

3 TNS Political & Social (2014) *Flash Eurobarometer 401: young people and drugs*. Luxembourg: European Commission. http://www.drugsandalcohol.ie/22196/

SERVICES

Cork and Kerry Alcohol Strategy 2016–2018

The *Cork and Kerry alcohol strategy 2016–2018: time for change* was launched in June 2016.[1] It is the first for the area and was informed by a literature review of 'alcohol and its influence at a global, national and local level'. This review is published as part of the strategy document. It includes literature from Ireland, the World Health Organization, and the European Union. In its conclusion, it identifies the introduction of minimum unit pricing, a reduction in availability, and increased restrictions on advertising and marketing as effective ways of reducing alcohol-related harms.

The strategy sets out its vision statement as 'motivating the communities in Cork and Kerry to stop the damage caused by alcohol', alongside its mission statement of 'building capacity in local communities through an advocacy, research and evidence based approach to change our relationship with alcohol'. It has six pillars, each of which has an overarching aim. Each aim in turn is underpinned by a set of objectives with defined actions, leads, timeframes, and key performance indicators.

1. Overarching pillar

Aim: To ensure that all actions are developed and implemented in the context of relevant national and local policy.

Objectives:

- Support the implementation of minimum unit pricing.
- Support the reduction in the availability of alcohol in local communities.
- Actively advocate for policy change and implementation to restrict the marketing of alcoholic products on a local, regional and national level.
- Include alcohol in the new national substance misuse strategy.

2. Education and prevention pillar

Aim 1: To increase the awareness of the impact of alcohol harm within the wider community.

Aim 2: To increase the general awareness of effective responses to alcohol harms at local level.

Objectives:

- Actively promote a general awareness of alcohol harms.
- Deliver evidence-based education and prevention programmes across Cork and Kerry.

3. Supply, access and availability pillar

Aim: To challenge the environment in which alcohol is made available and accessed.

Objectives:

- Educate communities in the law regarding sale and supply of alcohol.
- Review and challenge the current environment in which alcohol is available.

4. Screening, treatment and rehabilitation pillar

Aim: To increase the opportunity for people to access screening, treatment and rehabilitation services in Cork and Kerry.

Objectives:

- Inform local communities of drug and alcohol services.
- Build the capacity of communities to implement screening and interventions in their areas.
- Improve access to drug and alcohol services for local communities, especially in rural areas.

5. Research pillar

Aim: To conduct local research to support and underpin the Local Authority Action Plan.

Objective:

- Conduct research that will inform up-to-date practice in relation to evidenced-based harm reduction.

6. Monitoring and evaluation pillar

Aim: To monitor and evaluate the implementation of the Local Alcohol Action Plan to inform ongoing development.

Objectives:

- Continually monitor and evaluate the implementation of actions agreed with the Local Alcohol Action Plan.
- Continually monitor and evaluate the impact of our agreed actions.

Lucy Dillon

1 Cork and Kerry Alcohol Strategy Group (2016) *Cork and Kerry alcohol strategy 2016–2018*. Cork: Health Service Executive, Cork Local Drug & Alcohol Task Force, and Southern Regional Drug & Alcohol Task Force. http://www.drugsandalcohol.ie/25693/

National Drugs Library

UPDATES

Recent publications

The following abstracts are cited from published journal articles recently added to the repository of the HRB National Drugs Library at www.drugsandalcohol.ie

Adolescent substance use in the context of the family: a qualitative study of young people's views on parent-child attachments, parenting style and parental substance use

McLaughlin A, Campbell A and McColgan M (2016) *Substance Use & Misuse.* 51(14): 1846-1855
http://www.drugsandalcohol.ie/26088/

Adolescent substance use can place youth at risk of a range of poor outcomes. This article aimed to explore risk and protective factors for youth substance use within the context of the family with a view to informing family based interventions. Nine focus groups supplemented with participatory techniques were facilitated with a purposive sample of sixty-two young people (age 13-17 years) from post-primary schools across Northern Ireland.

Conclusion: Parenting programmes (tailored to mothers and fathers) may benefit young people via components on authoritative styles, parental monitoring, communication, nurturing attachments and parent-child conflict. Youth living with more complex issues, e.g. parental substance misuse, may benefit from programmes delivered beyond the family environment, e.g. school based settings.

Overview of the European university-based study programmes in the addictions field

Pavlovska A, Miovsky M, Babor T and Gabrhelik R (2016) *Drugs: Education Prevention and Policy* Early online.
http://www.drugsandalcohol.ie/26197/

We mapped and described university study programmes in the addictions field (USPA) in Europe, according to degrees, professional backgrounds, titles, methods of delivery, duration, entrance requirements, fees, clinical practice requirements and courses offered.

Conclusion: In recent years, the number of specialised education programmes that aim to prepare a new professional workforce has been growing. The findings provide a basis for discussion and cooperation among programmes and universities.

Substance misuse and behavioral adjustment problems in Irish adolescents: examining contextual risk and social proximal factors

Fitzgerald A, Maguire J and Dooley B (2016) *Substance Use & Misuse,* 51(13): 1790-1809
http://www.drugsandalcohol.ie/26022/

Using an ecological perspective to examine the roles of contextual factors and proximal social processes, the current study examined how family, peer, and school processes mediate the relationship between cumulative contextual risk and problem behavior, and whether these mediating relationships are moderated by gender.

Conclusion: The study provides valuable and practical implications for informing research, interventions, and social policy at family, peer, and school levels.

'Trip-sitting' in the black hole: a netnographic study of dissociation and indigenous harm reduction

Hearne E and Van Hout MC (2016) *Journal of Psychoactive Drugs,* 48(4): 233-242
http://www.drugsandalcohol.ie/25845/

An array of dissociative novel psychoactive substances, including 'methoxetamine', '3-MeO-PCP', and 'methoxphenidine', have emerged as substitutes for the illicit substance 'ketamine'. A netographic research methodology aimed to describe online, dissociative novel psychoactive substance users' perceptions of risk, informed knowledge around use, and indigenous harm-reduction practices as advocated within online drug fora, so as to provide credible information which can be used to inform public online health education and drug prevention.

Conclusion: Further research and consistent monitoring of Internet drug fora are advised to explore variations in harm-reduction tactics throughout dissociative NPS populations, and to consider how existing harm-reduction initiatives are influencing these hard-to-reach groups.

Attitudes and perceived risk of cannabis use in Irish adolescents

Barrett P and Bradley C (2016) *Irish Journal of Medical Science,* 185(3): 643-647
http://www.drugsandalcohol.ie/25818/

Cannabis is the most widely used illicit drug in the developed world and its use is associated with several adverse physical and mental health effects and negative social outcomes. Earlier use of cannabis increases the risk of adverse effects. Attitudes and perceived risk towards drugs are regarded as strong influences in determining whether or not a person uses cannabis, but there is little existing research on Irish teenagers' attitudes to the risks of this drug. This was a descriptive, cross-sectional study using a structured, anonymous questionnaire.

Recent publications continued

The study was undertaken in nine public and private secondary schools in Cork City and suburbs. Students aged 15-18 and in fourth, fifth or sixth year of school were included.

Conclusion: Cannabis use is very widespread among teenagers in Cork. There are relatively low levels of perceived risk of mental and physical health problems with use of the drug. Attitudes towards cannabis are associated with personal use of the drug and gender.

Alcohol drinking cultures of European adolescents

Bräker AB and Soellner R (2016) *European Journal of Public Health,* 26(4): 581-586
http://www.drugsandalcohol.ie/25801/

Adolescent alcohol use varies across Europe. Differences in use might be due to variations in social drinking norms. These norms become apparent, e.g. in different proportions of alcohol drinking types per country. This study's purpose is to cluster European countries according to prevalence rates of alcohol drinking habits among adolescents aged 12-16. The proportions of each drinking pattern per country (non, mild, episodic, frequent and heavy episodic use) across 25 European countries (N= 48,423, M=13.83 years, 48.5% male) are used as classifying variables.

Conclusion: When applying and developing intervention strategies, differences in adolescent alcohol drinking cultures (i.e. social drinking norms) within Europe should be focused on. Alcohol policies and prevention programs should take cultural aspects like social drinking norms into account.

RESPONSES

General practitioners tackle complex addictions: how complex interventions can assist in dealing with addiction

Klimas J (2016) *Irish Journal of Psychological Medicine* Early online.
http://www.drugsandalcohol.ie/26034/

Substance use disorder treatment is a complex problem. Complex problems require complex interventions, ideally tested via randomised controlled trials. Complex interventions are best developed in stages, using established implementation frameworks.

Conclusion: Starting with a historical patient case study, we explore how treatment of this challenging population group has been approached, how an evidence-based framework has informed formulation of a complex health intervention and how this has been progressed via the UK's Medical Research Council (MRC) approach.

Estimating the cost-effectiveness of brief interventions for heavy drinking in primary health care across Europe

Angus C, Thomas C, Anderson P, Meier PS and Brennan A (2016) *European Journal of Public Health* Early online.
http://www.drugsandalcohol.ie/26025/

Screening and Brief Interventions for alcohol are an effective public health measure to tackle alcohol-related harm, however relatively few countries across the European Union (EU) have implemented them widely. This may be due to a lack of understanding of the specific financial implications of such policies within each country.

Conclusion: Implementing national programmes of SBI in primary health care would be a cost-effective means of reducing alcohol-attributable morbidity and deaths in almost all countries of the EU.

Effectiveness of pharmacotherapies in increasing treatment retention and reducing opioid overdose death in individuals recently released from prison: a systematic review

Crowley D and Van Hout MC (2016) *Heroin Addiction and Related Clinical Problems* Early online.
http://www.drugsandalcohol.ie/25966/

Opioid dependence is common amongst the prison population, with increased risk of fatal overdose in the immediate post-release period. The study aimed to review the effectiveness of pharmacotherapies (Methadone (METH), Buprenorphine (BUP), levo-alpha acetyl methadol (LAAM), Naltrexone (NLT) and Naloxone (NLX)) in reducing overdose deaths and increasing treatment retention in opioid dependent prisoners on release.

Conclusion: The review underscores the need for prisoners on AOT to be supported with continued treatment on release into the community. Further research is warranted to investigate potential utility of long-acting NLT formulations and take-home NLX (THN) in pre-release opioid dependent prisoners.

Parenthood, child care, and heroin use: outcomes after three years

Comiskey CM, Hyland J and Hyland P (2016) *Substance Use & Misuse,* 51(12): 1600-1609
http://www.drugsandalcohol.ie/25951/

Internationally there is a lack of measurement on the impact of childcare on people who use drugs. The aim of this article was to longitudinally measure drug use, familial and social status and criminal involvement between parents and nonparents who use heroin and have children in their care.

Conclusion: While caring for children was associated with reduced heroin use at 3 years, living with a person who used at intake removed this effect, thus indicating that while individual based addiction theories reflected observed outcomes, social network connectedness was more influential.

Variation between hospitals in inpatient admission practices for self-harm patients and its impact on repeat presentation

Carroll R, Corcoran P, Griffin E, Perry I, Arensman E, Gunnell D and Metcalfe C (2016) *Social Psychiatry and Psychiatric Epidemiology* Early online.
http://www.drugsandalcohol.ie/25875/

Self-harm patient management varies markedly between hospitals, with fourfold differences in the proportion of patients who are admitted to a medical or psychiatric inpatient bed. The current study aimed to investigate whether differences in admission practices are associated with patient outcomes (repeat self-harm) while accounting for differences in patient case mix.

Conclusion: No strong evidence was found to suggest medical admission reduces the risk of repeat self-harm. Models of health service provision that encourage prompt mental health assessment in the emergency department and avoid unnecessary medical admission of self-harm patients appear warranted. Psychiatric inpatient admission may be associated with a heightened risk of repeat self-harm in some patients, but these findings could be biased by residual confounding and require replication.

Recent publications continued

Focused interventions for injecting drug users

Keane M and Hogarthy S (2016) *World of Irish Nursing & Midwifery,* 24(5): 66-67
http://www.drugsandalcohol.ie/25820/

The authors discuss the need for supervised injecting facilities as a safer alternative to addicts injecting in public.

The article particularly focuses on what supervised injecting facilities are and how injecting facilities operate.

Medical professionals' perspectives on prescribed and over-the-counter medicines containing codeine: a cross-sectional study

Foley M, Carney T, Rich E, Parry C, Van Hout MC and Deluca P (2016) *BMJ Open,* 6(7): e011725
http://www.drugsandalcohol.ie/25819/

Objectives were to explore prescribing practitioners' perspectives on prescribed codeine use, their ability to identify dependence and their options for treatment in the UK. A cross-sectional design using a questionnaire was used with a nationally representative sample of 300 prescribing professionals working in the UK.

Conclusion: Communication with patients should involve assessment of patient understanding of their medication, including the risk of dependence. There is a need to develop extra supports for professionals including patient screening tools for identifying codeine dependence. The support structure for managing codeine-dependent patients in primary care requires further examination.

Effect of integrating HIV and addiction care for non-engaging HIV-infected opiate-dependent patients

Kinahan JC, Surah S, Keating S, Bergin C, Mulcahy F, Lyons F and Keenan E (2016) *Irish Journal of Medical Science,* 185(3): 623-628
http://www.drugsandalcohol.ie/25816/

HIV-positive substance dependent patients contribute disproportionally to HIV morbidity and mortality as a result of poor compliance with their HIV treatment. This study aims to establish if integrating HIV and addiction care has a significant effect on addiction and HIV morbidity for non-engaging HIV-positive opiate-dependent patients.

Conclusion: Integration of HIV and addiction care optimises the physical health of non-engaging HIV-positive opiate-dependent patients with no substantial effect on their methadone maintenance programme.

Determining rates of smoking cessation advice delivered during hospitalisation and smoking cessation rates 3 months post discharge: a two-hospital survey

Mellon L, McElvaney NG, Cormican L, Hickey A, Conroy R, Ekpotu L, Oghenejobo O, Atteih S, McDonnell R and Doyle F (2016) *Health Psychology and Behavioral Medicine,* 4(1): 124-137
http://www.drugsandalcohol.ie/25796/

This study aimed to determine the prevalence of smoking and cessation advice received by inpatients in two teaching hospitals in Ireland, and the impact of cessation advice on smoking at 3 months post discharge.

Conclusion: This observational study finds that provision of brief cessation advice and smoking status documentation was suboptimal. Where advice was given, it was associated with enhanced motivation to quit and increased quit rates. These findings, along with low dependence scores, suggest that systematic provision of low-intensity cessation interventions could significantly enhance quit rates in hospitalised smokers.

Factors associated with non-retention in HIV care in an era of widespread antiretroviral therapy

O'Connell S, O'Rourke A, Sweeney E, Lynam A, Sadlier C and Bergin C (2016) *International Journal of STD & AIDS* Early online
http://www.drugsandalcohol.ie/25952/

In an era of antiretroviral therapy (ART) for all HIV-1-infected patients, our primary aim was to describe prevalence and characteristics of patients disengaged from care at an urban ambulatory HIV clinic. We conducted a nested case-control study. All patients who disengaged from care (defined as being lost to follow-up for at least one year) from 2007 to 2014 inclusive were identified. Cases were matched to controls in a 1:4 ratio. A total of 1250 cases were included; 250/2289 (10.9%) of patients attending our HIV clinic disengaged from 2007 to 2014. One hundred and twenty-six (50.4%) were heterosexual, 81 (32.4%) were men who have sex with men and 40 (16%) were intravenous drug users.

Conclusion: On univariate analysis only, patients with heterosexual risk were more likely to disengage from care. Those who disengaged were younger, mean age of 39. A higher proportion of patients who disengaged from care was not receiving ART and did not have a suppressed HIV-1 viral load. On multivariable analysis, Irish patients were less likely to disengage from HIV care. Factors associated with non-retention in HIV care have been identified. A semi-structured interview of those patients who re-engaged will take place to further examine reasons for disengagement from care.

Drugnet Ireland is the quarterly newsletter of Ireland's focal point for the EMCDDA and is produced in collaboration with the HRB National Drugs Library. *Drugnet Ireland* is published by the Health Research Board.

Managing editor: Brian Galvin
Copy-editing: O'Hanlon Media
Production: Fiona Bannon

Health Research Board
Grattan House
67-72 Lower Mount Street
Dublin 2
D02 H638
T: 01 234 5168
E: drugnet@hrb.ie
W: www.hrb.ie